

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

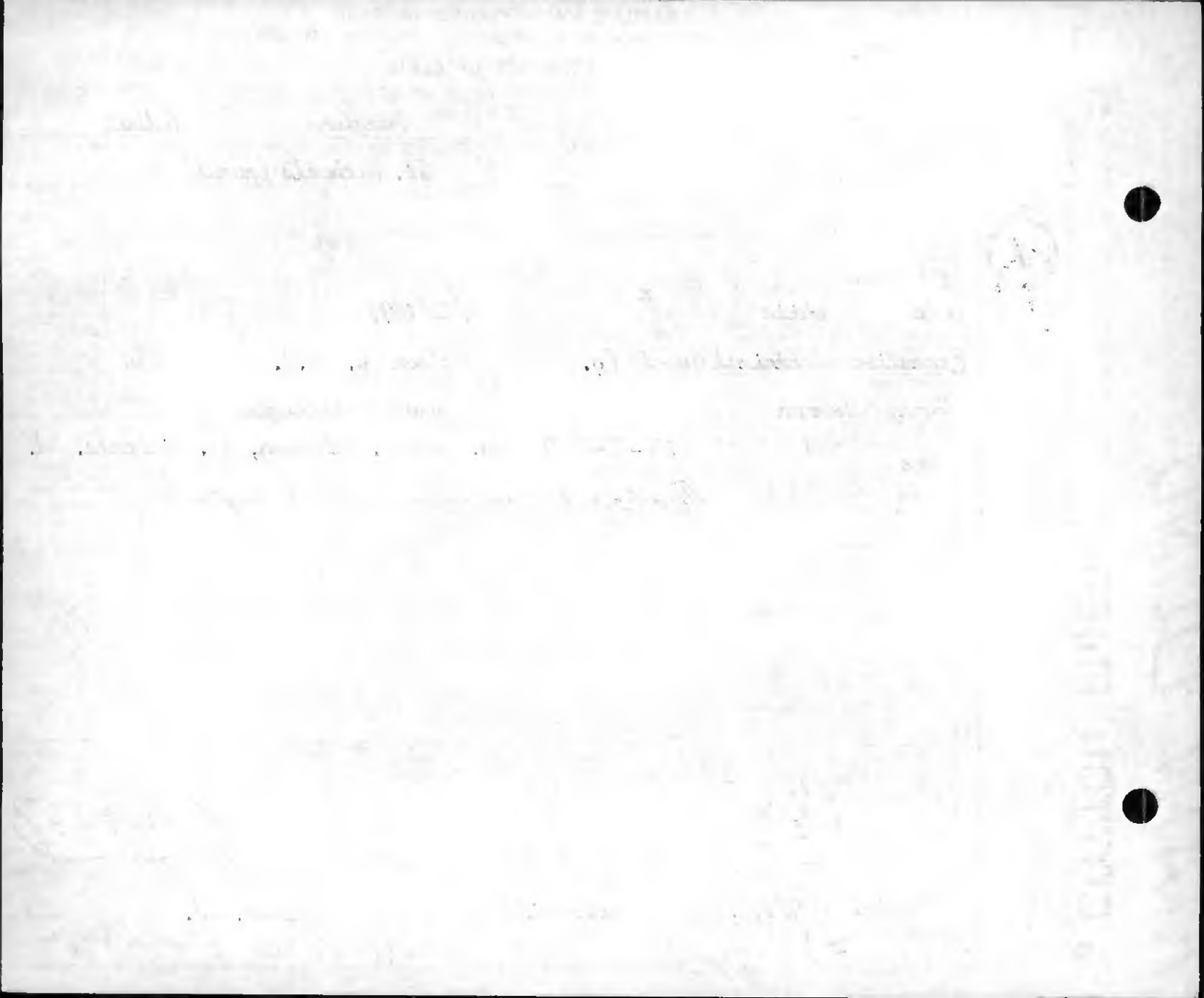
12973

12984

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels (rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>ALAN</b> Last <b>ACKERMAN</b>		4. DATE OF DEATH Month <b>9</b> - Day <b>16</b> - Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/22/1899</b>
9. AGE (In years last birthday) yrs. <b>68</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive electrical Supply Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hudson Co. N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Ackerman</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Stelelze</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>138-22-8404</b>	
17. INFORMANT <b>Mrs. John A. Ackerman, St. Michaels, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive myocardial infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <b>12/19/1967</b> and that death occurred at <b>5:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>E. C. H. Schmidt</b>		22b. DATE SIGNED <b>1659567</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>		22d. ADDRESS <b>Easton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<b>Burial</b>	<b>9/19/1967</b>	<b>Spring Hill</b>	<b>Easton, Md.</b>
24. FUNERAL DIRECTOR <b>Maurice F. Newkome</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 20 1967</b>	
ADDRESS <b>Easton, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 12 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

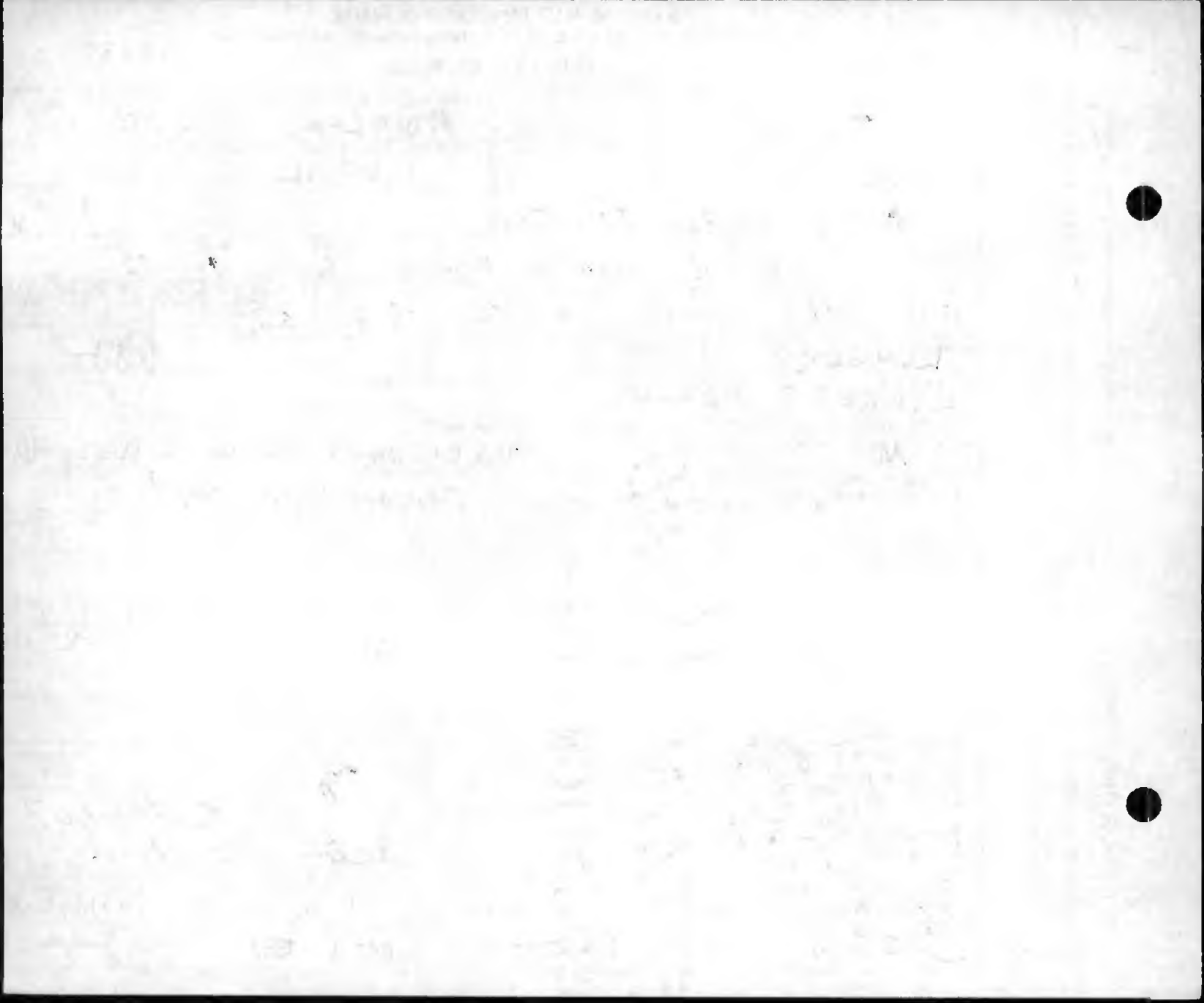
12980

CERTIFICATE OF DEATH

12985

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL RIDGELY 05.2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DALLAS</b> Middle <b>AUSTIN</b> Last <b>ADKINS</b>		4. DATE OF DEATH Month <b>9</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 18, 1910</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LUMBER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>EVERETT ADKINS</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.  17. INFORMANT <b>MRS. EUGENIA ADKINS, RIDGELY MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub-arachnoid hemorrhage, left</b> <b>330X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH  19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>7:40</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>E. C. H. Schmidt</b>		22b. DATE SIGNED <b>27 Sept 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>		22d. ADDRESS <b>Easton, Maryland</b>	
23a. BURIAL CREMATION REMOVAL (Specify)	23b. DATE THEREOF <b>SEPT. 30, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RIDGELY</b>	23d. LOCATION (City or town) (County) (State) <b>RIDGELY MARYLAND</b>
24. FUNERAL DIRECTOR <b>Charles Moore</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 4 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12981

12986

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>DELAWARE</u> b. COUNTY <u>BENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>13 1/2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BURRSVILLE</u> <u>46.3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp.</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Harriett</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>8</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26, 1906</u> <u>FEB 15, 1911</u>	9. AGE <u>60</u> years (last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN SINGER</u>				14. MOTHER'S MAIDEN NAME <u>LIBBY MURPHY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>PAUL SINGER, DENTON MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X Congestive heart failure</u> DUE TO (b) <u>Rheumatic heart disease with</u> DUE TO (c) <u>mitral regurgitation and atrial fibrillation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>febrile</u>							INTERVAL BETWEEN ONSET AND DEATH <u>uncertain</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-8</u> , 19 <u>67</u> , to <u>9-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-8</u> 19 <u>67</u> , and that death occurred at <u>2:55 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert W. Trever</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>		M.D.		22d. ADDRESS <u>Easton, Maryland</u>		9/8/67	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>SEPT. 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DENTON</u>		23d. LOCATION (City or Town) (County) (State) <u>DENTON MD.</u>	
24. FUNERAL DIRECTOR <u>CHARLES V. MOORE</u>				25a. REC'D BY REGISTRAR <u>SEP 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

STATE OF CALIFORNIA

10-1-77

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12982

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12987

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>			c. LENGTH OF STAY IN 1b <b>3 months</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>II9 S. Hanson</b>				d. STREET ADDRESS <b>II9 S. Hanson</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Delores</b> Middle <b>Bostic</b> Last				4. DATE OF DEATH Month <b>Sept.</b> Day <b>28</b> Year <b>1967</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-3- 1967</b>		9. AGE (In years last birthday) <b>3</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days	IF UNDER 24 HRS. Hours <b>3</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mack Dawson</b>				14. MOTHER'S MAIDEN NAME <b>Mildred Mitchell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mildred Mitchell</b> Address <b>Easton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>501X</b> DUE TO <b>Sepsis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Laryngotracheobronchitis</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Louis V. Veltje</b>		M.D. <b>V. Veltje</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>9-24-67</b>	
EXAMINER'S NAME (Type) <b>V. Veltje</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>9-29- 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Richards</b>		23d. LOCATION (City or Town) (County) (State) <b>Easton Talbot Md.</b>	
24. FUNERAL DIRECTOR <b>B.L. Dashiell</b> Address <b>Easton, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 2 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

11/11/51

Mr. [illegible]

Dear Sir:

Enclosed

for you

are

two copies

of the

report

on the

subject

of the

same

and

the

copy

of the

report

on the subject of the

same

is

Very truly yours,

[Signature]

Very truly yours,

[Signature]

Very truly yours,

[Signature]

Very truly yours,

Very truly yours,

[Signature]

Very truly yours,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12983

12988

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Neavitt</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Neavitt</b>			
c. LENGTH OF STAY IN 1b <b>Life</b>				d. STREET ADDRESS <b>20.1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>-----</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>JANE</b> Last <b>BRIDGES</b>				4. DATE OF DEATH Month <b>September</b> Day <b>2</b> Year <b>19 67</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 23, 1893</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
11. BIRTHPLACE (County & State, or foreign country) <b>Talbot County, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Levin Fisher</b>				14. MOTHER'S MAIDEN NAME <b>Frances Hill</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-32-7095-B</b>		17. INFORMANT <b>Weldon Bridges, Neavitt, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>atherosclerotic cardiovascular</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension Ext Vas</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1953</b> 19 to <b>9-2-67</b> 19, that (I) (we) last saw the deceased alive on <b>9-2</b> 19 <b>67</b> , and that death occurred at <b>1:39</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Guy M. Reeser, Jr.</b>				22b. DATE SIGNED <b>9-5-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>GUY M. REESER, Jr., M. D.</b>				22d. ADDRESS <b>St. Michaels, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept 4, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Neavitt Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Neavitt, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harmon E. Leonard</b>				25a. REC'D BY REGISTRAR <b>SEP 6 1967</b>			
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>							

THE CHURCH OF ENGLAND

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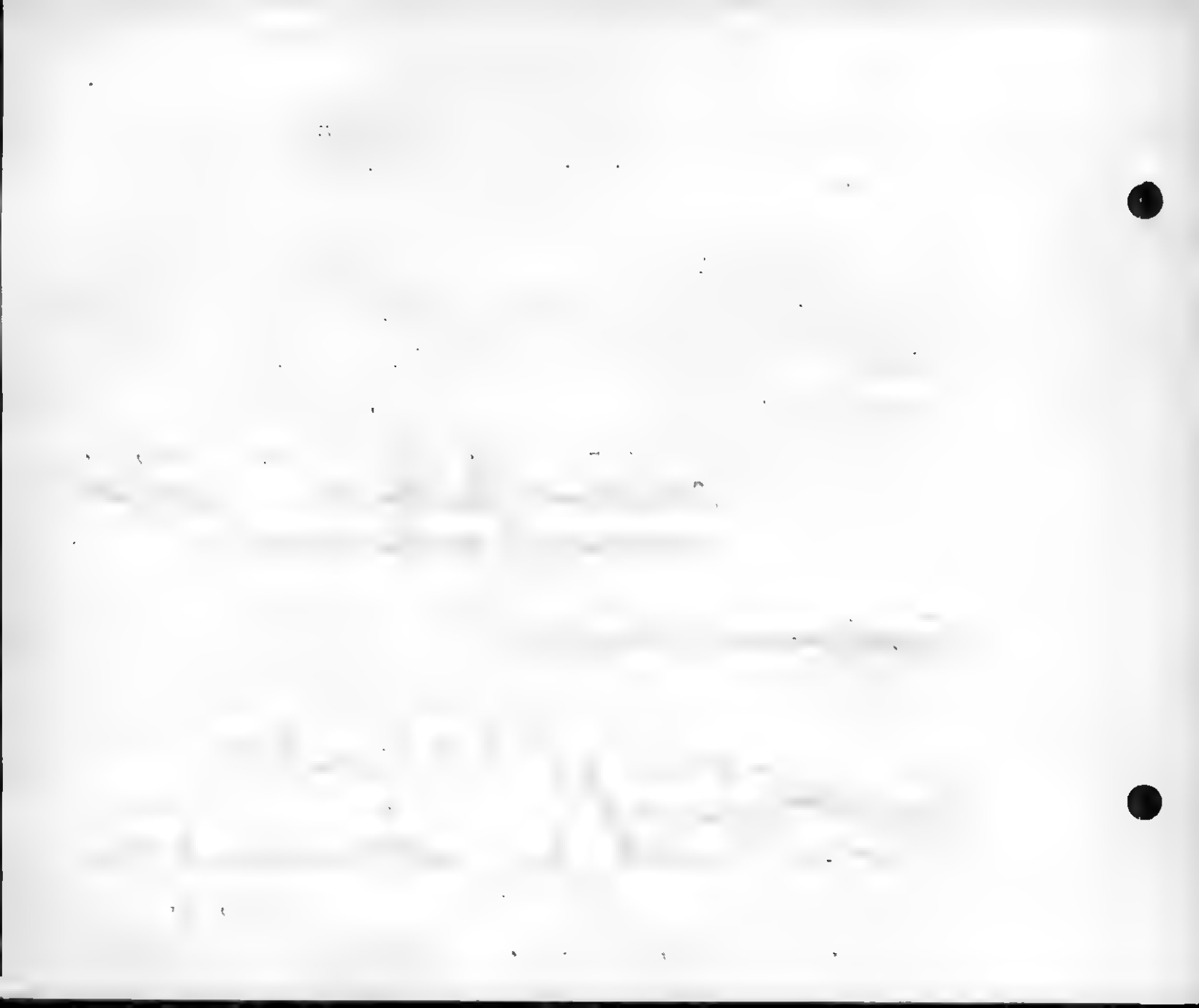
12989

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Tilghman</u>	
3. NAME OF DECEASED (Type or print) <u>Andrew Cummings</u>		4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/15/1891</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Talbot Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Cummings</u>		14. MOTHER'S MAIDEN NAME <u>Laura V. Birmingham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-05-8360</u>	
17. INFORMANT <u>Mrs. Andrew Cummings, Tilghman, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac failure</u> months <u>120.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>coronary &amp; cardio vascl.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema - severe</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-30-67</u> to <u>9-30-67</u> , that (I) (we) last saw the deceased alive on <u>9-30-1967</u> and that death occurred <u>11:30</u> A.M. from causes and on the date stated above			
22a. SIGNATURE <u>Raym Breese</u>		22b. DATE SIGNED <u>10-2-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>St Michael med</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<u>Burial</u>		<u>10/3/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pilgrim Holiness</u>		23d. LOCATION (City or Town) (County) (State) <u>Tilghman, Md.</u>	
24. FUNERAL DIRECTOR <u>MAURICE E. NEUNAM &amp; SON, Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Johnas Judge</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

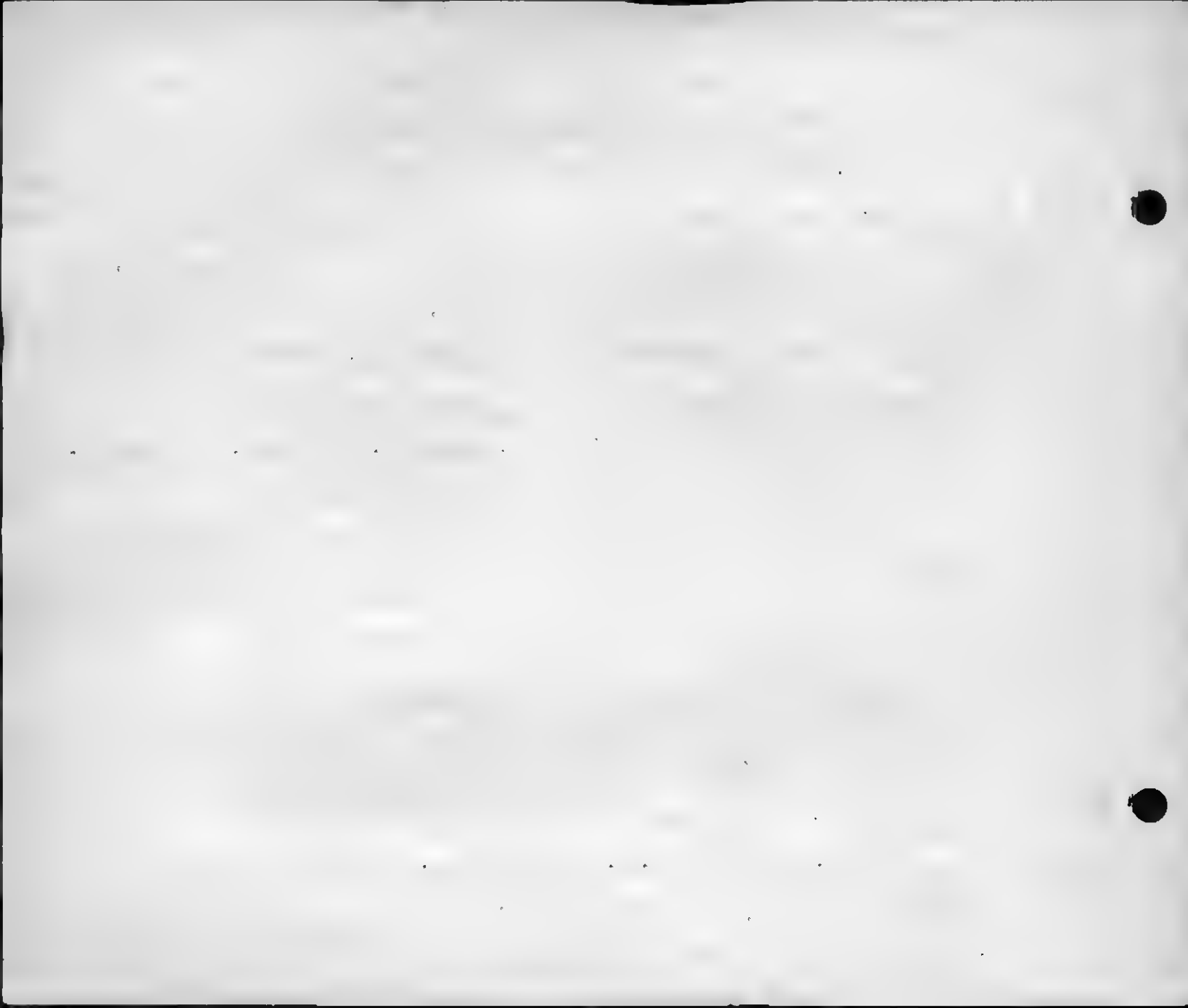
## CERTIFICATE OF DEATH

12980

12990

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Talbot</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - St. Michaels</u> c. LENGTH OF STAY IN b. <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rio Vista Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>McDaniel,</u> d. STREET ADDRESS <u>-----</u>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>WILLIAM HASTING DERBYSHIRE</u> SEX <u>Male</u>				<b>4. DATE OF DEATH</b> <u>September 11, 1967</u> Month Day Year							
<b>5. COLOR OR RACE</b> <u>White</u>				<b>6. DATE OF BIRTH</b> <u>Aug 22, 1895</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>							
<b>8. AGE</b> (In years last birthday) <u>72 yrs.</u> IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>				<b>9. BIRTHPLACE</b> (County & State, or foreign country) <u>Philadelphia, Pennsylvania</u> <b>10. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Ret Purchasing Agent</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Engineering</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Philadelphia, Pennsylvania</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>Henry Edwin Derbyshire</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Laura Melville Smith</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>WWI</u>				<b>16. SOCIAL SECURITY NO.</b> <u>185-03-0751</u>							
<b>17. INFORMANT</b> <u>Mrs. Kathryn K. Derbyshire, McDaniel, Md.</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO (b) <u>Cerebral aneurysm of kidney</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pathologic Fracture R. Hip</u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>				<b>20f. (City or town)</b> (County) (State) <u>  </u>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 1967</u> <b>to</b> <u>Sept 11, 1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Sept 11, 1967</u> , <b>and that death occurred at</b> <u>8:35 P.M.</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>R. Lane Wroth</u>				<b>22b. DATE SIGNED</b> <u>9-12-67</u>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>R. LANE WROTH, M. D.</u>				<b>22d. ADDRESS</b> <u>St. Michaels, Maryland</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Sept 14, 1967</u>							
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Spring Hill Cemetery</u>				<b>23d. LOCATION (City, town or county)</b> (State) <u>Easton, Maryland</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harrison E. Leonard</u>				<b>25a. REC'D BY REGISTRAR</b> <u>SEP 18 1967</u>							
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				<b>25c. REGISTRAR'S SIGNATURE</b> <u>  </u>							

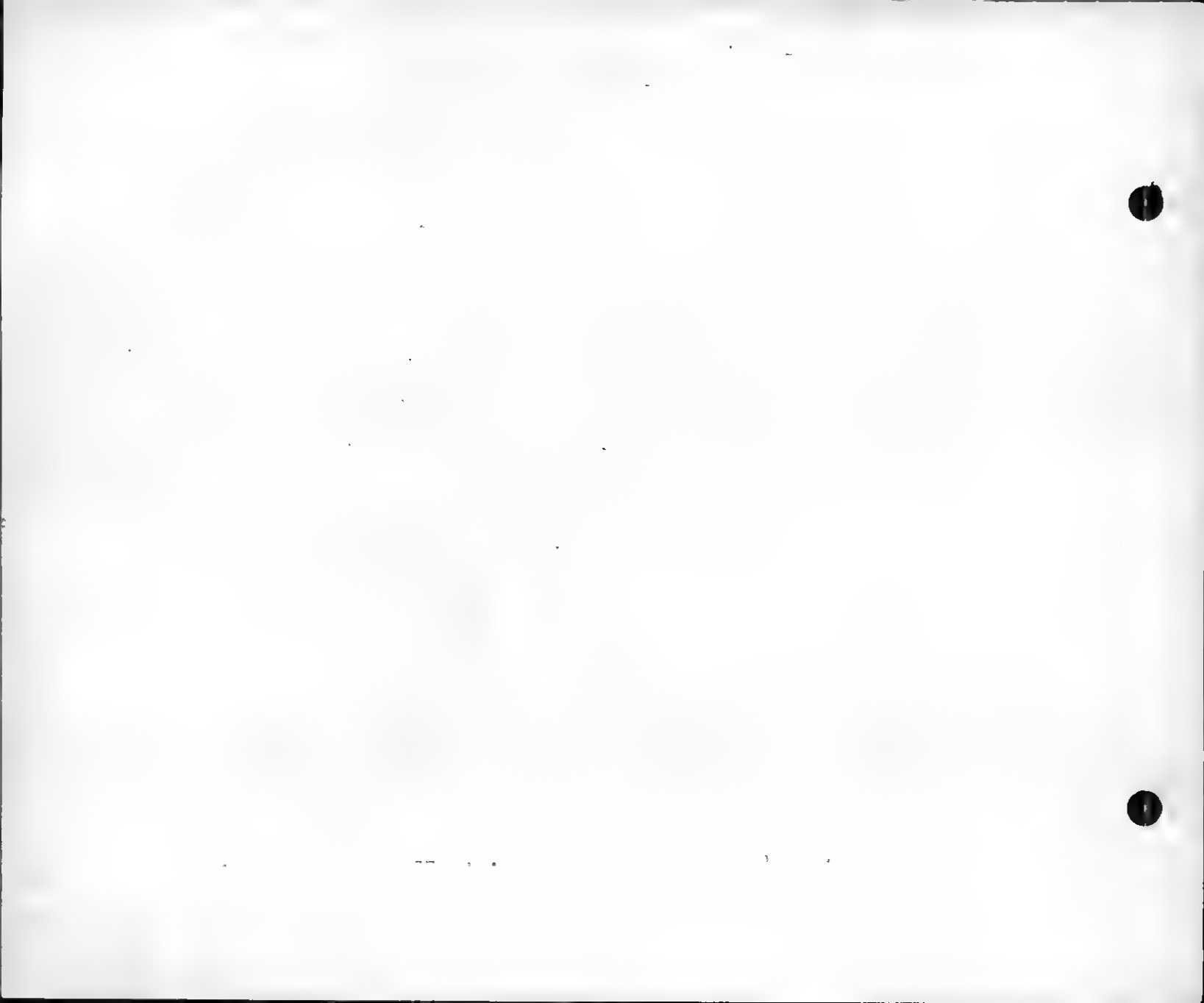
TO HOSPITAL ☐ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove person papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
12991									
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>			c. LENGTH OF STAY IN lb <u>45 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>					d. STREET ADDRESS <u>GRACE ST.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ERNEST MILTON</u> First Middle Last <u>DYOTT</u>					4. DATE OF DEATH <u>9-17-1967</u> Month Day Year				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 31, 1890</u>		9. AGE (In years last birthday) <u>77</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ST. MICHAELS</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>JAMES A. DYOTT</u>					14. MOTHER'S MAIDEN NAME <u>MARY WILLEY</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>YES WWI</u>		16. SOCIAL SECURITY NO. <u>212-16-9854</u>		17. INFORMANT <u>Ernest Dyott, St. Michaels Md</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chronic Pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Pyelonephritis</u> DUE TO <u>Chronic Pyelonephritis</u> (c) <u>Chronic Pyelonephritis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>67</u> , to <u>Sept 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>16 Sept</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above.									
22a. SIGNATURE <u>R. Lane Wroth</u>					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>9-18-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>R. Lane Wroth</u>					22d. ADDRESS <u>M.D. St. Michaels, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)			
<u>Burial</u>		<u>Sept 19, 1967</u>		<u>Olivet Cemetery</u>		<u>St. Michaels, Maryland</u>			
24. FUNERAL DIRECTOR <u>Harison E. Leonard, St. Michaels, Md</u> ADDRESS					25. REC'D BY REGISTRAR <u>SEP 21 1967</u> DATE		25a. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12987

12992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>15 HR. - 50 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		d. STREET ADDRESS <u>Rt-1, Box 22A - PRESTON</u>	
3. NAME OF DECEASED (Type or print) First <u>Lucille</u> Middle <u>Green</u> Last <u>Green</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-06</u>
9. AGE (In years last birthday) <u>61</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	11. BIRTHPLACE (County & State, or foreign country) <u>SAVANNAH, GEORGIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN</u>	
14. MOTHER'S MAIDEN NAME <u>CLARA BROWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>217-28-4219</u>		17. INFORMANT <u>MARY ALICE WALLACE, HURLOCK, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>&lt; 24 hrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-24</u> , 19 <u>67</u> , to <u>9-25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-24</u> 19 <u>67</u> , and that death occurred at <u>2:58 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED <u>9-27-67</u>	22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever, M.D.</u>
22d. ADDRESS <u>Easton, Md.</u>		22e. DATE <u>SEP 29 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FEDERALS BURG</u>	23d. LOCATION (City or Town) (County) (State) <u>Caroline Co. Maryland</u>
24. FUNERAL DIRECTOR <u>Barbara Dashiell</u>		25. REG. BY REGISTRAR <u>Charles Judge</u>	

VR A15 (4)  
25M 1/67

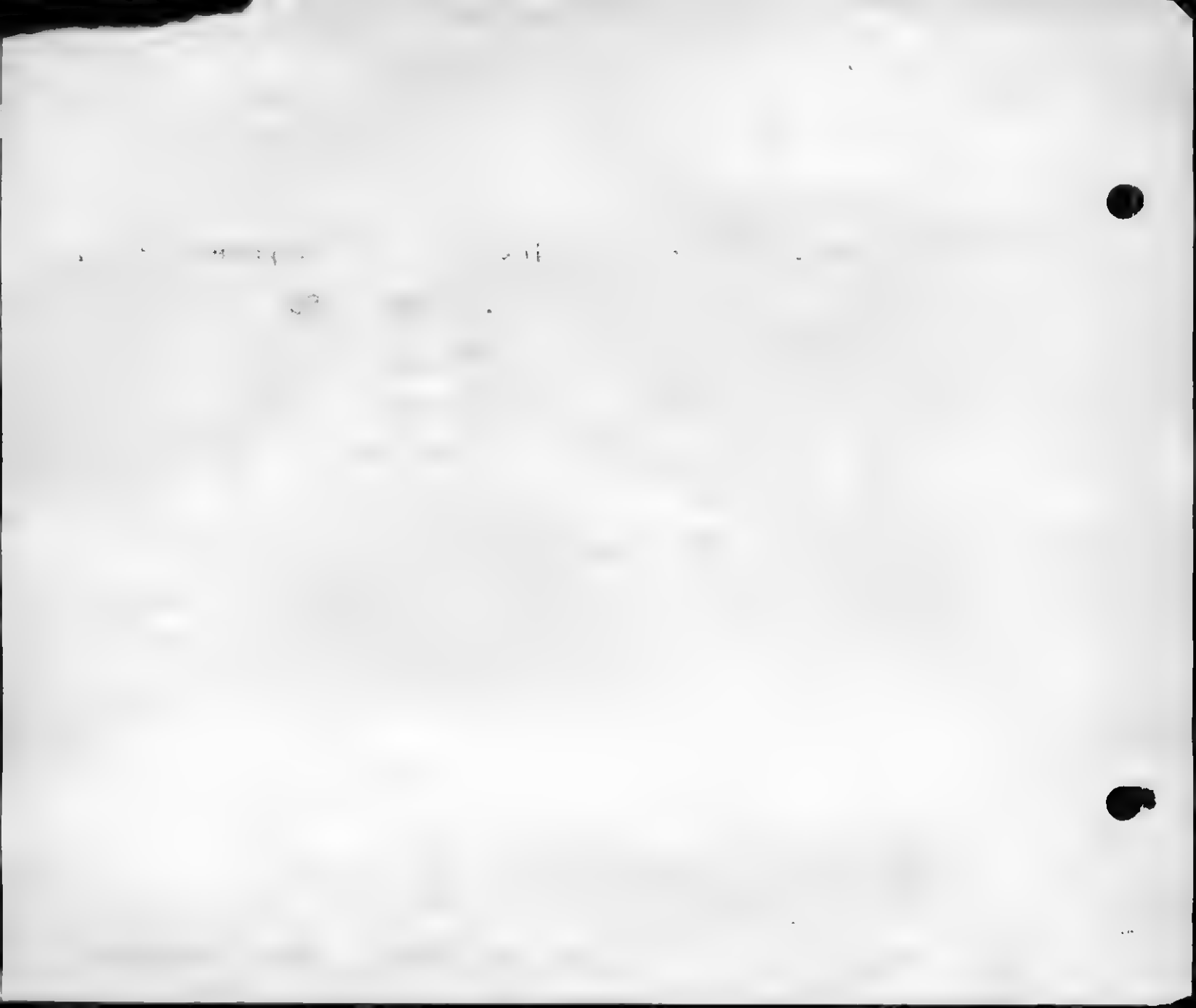
10/19/67



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
12988									
1. PLACE OF DEATH a. COUNTY <b>Talbot</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>					c. LENGTH OF STAY IN 1b <b>1MO-9 Days</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOUSE IN THE PINES-EASTON, MD.</b>					d. STREET ADDRESS <b>Preston</b>				
3. NAME OF DECEASED (Type or print) <b>MARGARET B. HENNEY</b>					4. DATE OF DEATH Month <b>September</b> Day <b>28</b> Year <b>1967</b>				
5. SEX <b>Female</b>					6. COLOR OR RACE <b>White</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>Dec. 18-86</b>				
9. AGE (In years) <b>80</b> yrs.					10. AGE (In years) If UNDER 1 YEAR Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min. <b>80</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Nurse</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Phil. Pa.</b>				
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13. FATHER'S NAME <b>Olge Schroeder</b>					14. MOTHER'S MAIDEN NAME <b>Dorothea Meyer</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>431-20-0054</b>				
17. INFORMANT <b>Lt. Col. Martin Schroeder</b>					Address <b>4750 Kenmore Ave. Alexandria, VA.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1750 Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <b>Metastatic adenocarcinoma of the ovary</b>					INTERVAL BETWEEN ONSET AND DEATH <b>&gt; 6 wks.</b> <b>&gt; 6 wks.</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.									
22a. SIGNATURE <b>Robert W. Trever</b>					22b. DATE SIGNED <b>239</b>				
22c. PHYSICIAN'S NAME (Type) <b>M.D.</b>					22d. ADDRESS <b>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					23b. DATE THEREOF <b>9/30/1967</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>LAKEVIEW MEMORIAL PARK</b>					23d. LOCATION (City, town or county) (State) <b>MERCHANTVILLE, N.J.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newman + Son</b>					25a. REC'D BY REGISTRAR <b>Easton, Md.</b>				
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					DATE <b>OCT 3 1967</b>				



TO HOSPITAL ☒ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

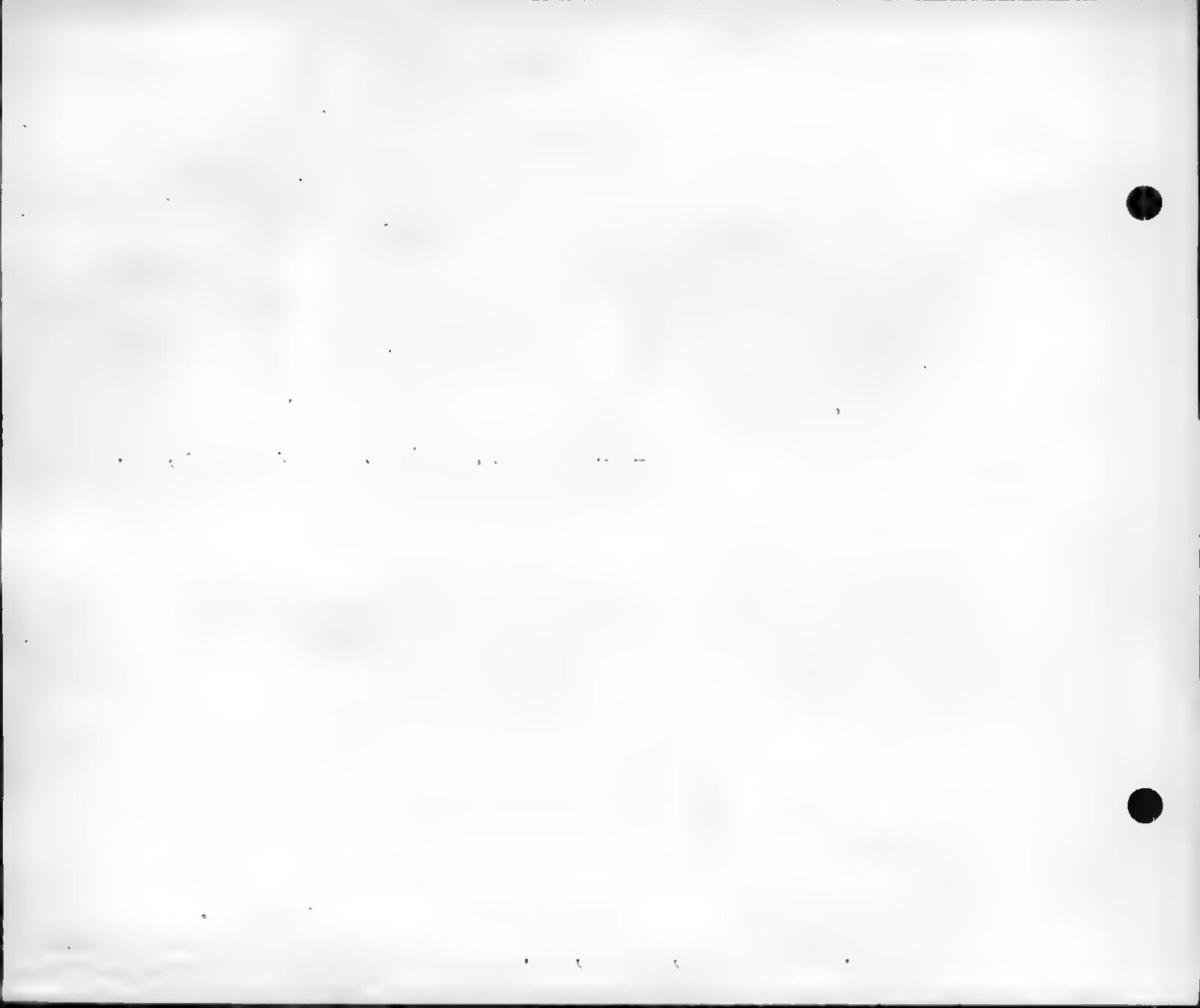
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12983 Item #2b,c & d Film #3-93 10/11/67 PH

CERTIFICATE OF DEATH

12994

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot/ Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxford (rural)</i>		c. LENGTH OF STAY IN It <i>4 months</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Sailor's Retreat</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxford (rural) Balto. 21204</i>	
d. STREET ADDRESS <i>Sailor's Retreat</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edwin Eugene Hooper</i>		4. DATE OF DEATH Month <i>9</i> Day <i>21</i> Year <i>19 67</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/17/1884</i>
9. AGE (In years last birthday) <i>83</i> yrs		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Pro. Baseball player &amp; Coach</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baseball</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel H. Hooper</i>		14. MOTHER'S MAIDEN NAME <i>Adeline Kennard</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO <i>215-50-2939</i>	
17. INFORMANT <i>Mrs. Edwin E. Hooper, Oxford, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Branchopneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Parkinson's m</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>67</i> , to <i>9/21</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>9/14</i> , 19 <i>67</i> , and that death occurred at <i>6:35 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>R. M. McDonald, M.D.</i>		22b. DATE SIGNED <i>9/28/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. M. McDonald, M.D.</i>		22d. ADDRESS <i>25. Hanson St. Easton, Md.</i>	
23a. BURIAL, CREMATION, REPOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>9/25/1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oxford</i>	23d. LOCATION (City or Town) (County) (State) <i>Oxford, Md.</i>
24. FUNERAL DIRECTOR <i>MAURICE E. NEUNAM &amp; SON, EASTON, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 27 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



4- 1 (M)

12990

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12995

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>24 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		d. STREET ADDRESS <b>509 GOLDSBOROUGH ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Esther</b> Middle <b>Virginia</b> Last <b>Hoxter</b>		4. DATE OF DEATH Month <b>9</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-2-93</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>xx</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Q.A.Co. MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>B.L. THOMAS</b>		14. MOTHER'S MAIDEN NAME <b>Georgia A. Lewis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-3579</b>	
17. INFORMANT <b>T.O. HOXTER</b>		Address <b>SEAFORD, DELAWARE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Diffuse interstitial fibrosis of the lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Unknown</b> (c) <b>Unknown</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>9:55 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Robert W. Trever</b>		22b. DATE SIGNED <b>9/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert W. Trever</b>		22d. ADDRESS <b>M.D. Easton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>SEPT 10</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>STEVENSVILLE</b>		23d. LOCATION (City or Town) (County) (State) <b>STEVENSVILLE MD.</b>	
24. FUNERAL DIRECTOR <b>Edgar L. Lane Church Hill Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 11 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

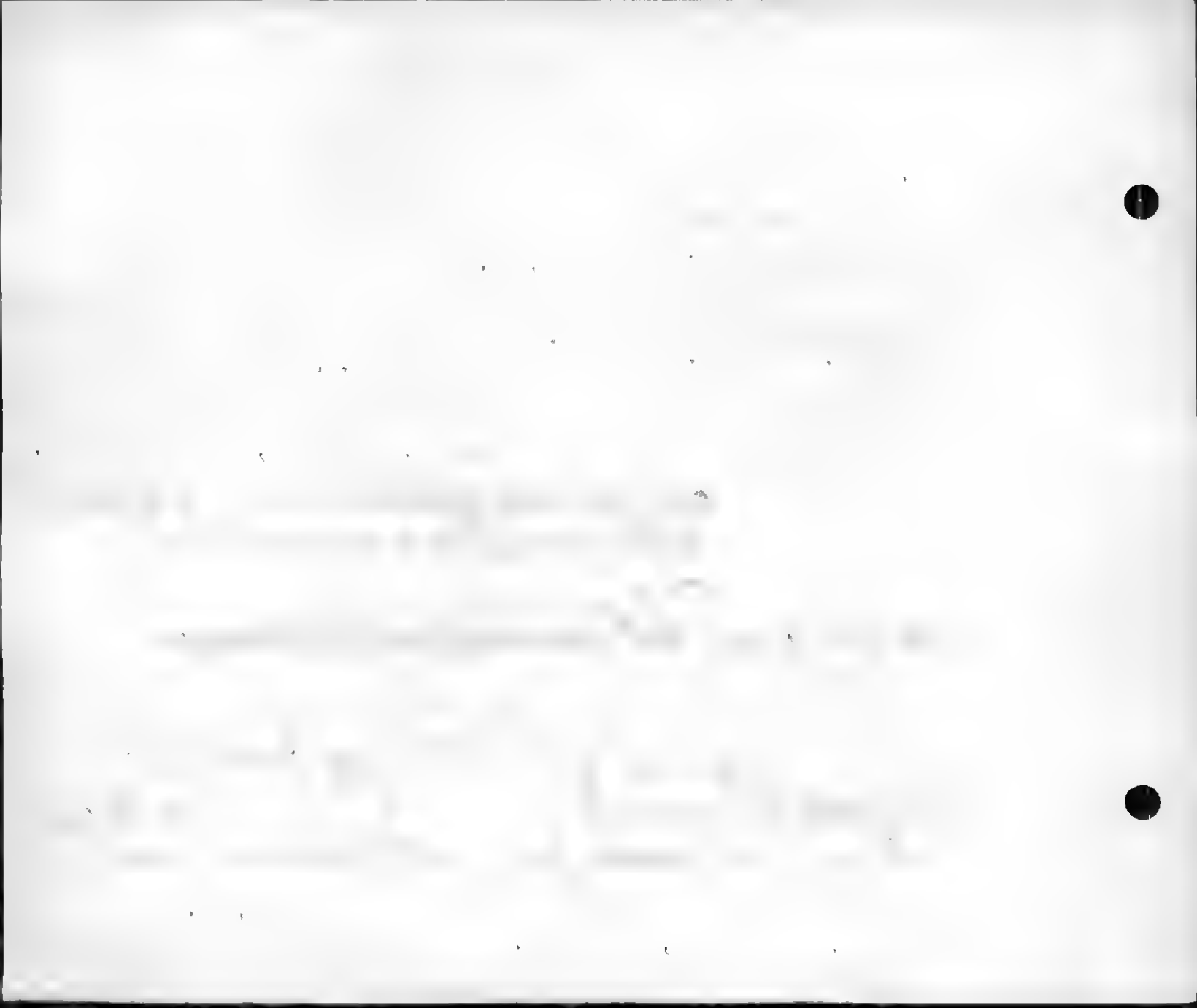
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12996

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

1 PLACE OF DEATH a COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Talbot</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels (rural)</u>		c LENGTH OF STAY IN 1b <u>5 years</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Rio Vista Nursing Home</u>		e STREET ADDRESS <u>Bellevue</u>	
3 NAME OF DECEASED (Type or print) <u>Harold Francis Hutchinson, Sr.</u>		4 DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>67</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>1/1/1882</u>
9 AGE (In years lost birthday) <u>85</u> yrs.		10 IF UNDER 1 YEAR Months _____ Days _____	11 IF UNDER 24 HRS Hours _____ Min. _____
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dairy Dept. Borden Co.</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Kings N.Y.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Kings N.Y.</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>John Hutchinson</u>		14 MOTHER'S MAIDEN NAME <u>Catherine Wilson</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>067-05-5299</u>	
17 INFORMANT <u>Harold F. Hutchinson, Jr.</u>		Address <u>Bellevue, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac failure</u> DUE TO <u>ATH. cardio + unbro vasc</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>as above</u> DUE TO (c) <u>as above</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cachexia, advanced senile changes</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>as above</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>as above</u>	20f (City or town) (County) (State) <u>as above</u>
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , to <u>9-25</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9-25</u> 19 <u>67</u> , and that death occurred at <u>3:05 p</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Wm M Reesor Jr</u>		22b DATE SIGNED <u>9-26-67</u>	
22c PHYSICIAN'S NAME (Type or print) <u>Wm M Reesor Jr</u>		22d ADDRESS <u>St Michaels Md</u>	
23a BURIAL, CREMATION, or other disposition (City) <u>Buried</u>	23b DATE THEREOF <u>9/29/1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial Park</u>	23d LOCATION (City or town) (County) (State) <u>Easton, Md.</u>
24. FUNERAL DIRECTOR <u>MURICE E. NEUNAM &amp; SON, Easton, Md.</u>		25a REC'D BY REGISTRAR DATE <u>SEP 27 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

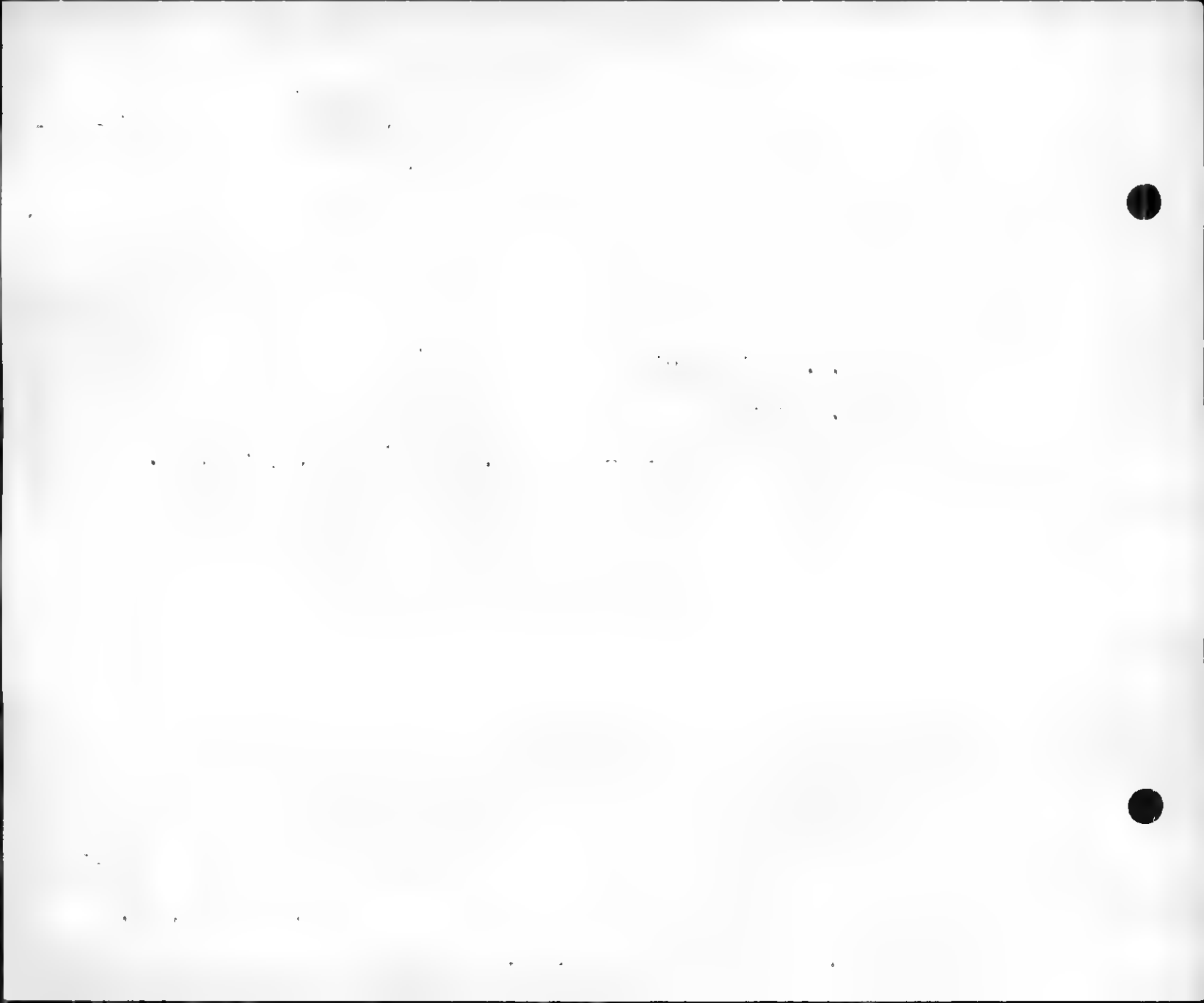
12992

**CERTIFICATE OF DEATH**

12997

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Talbot</u> MARYLAND				<b>2 USUAL RESIDENCE</b> (Write in full, including street address, if institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN TB _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>				d. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>WILLIAM JAMES JACKSON</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>9 10 19 67</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/21/89</u>		9. AGE (In years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life - even if retired) <u>Engineer U.S. Public Service</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State or foreign country) <u>Talbot</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William H. Jackson</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Ann Cooper</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO <u>212-09-4656</u>				17. INFORMANT Address <u>Mrs. Fred Eberhard, Easton, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Myocardial hypertrophy</u> (c) <u>Gangrene left leg</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) (County) (State) _____		21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased on _____, 19____, and that death occurred at <u>6:02</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>E. C. H. Schmidt</u>			22b. DATE SIGNED <u>11 Sep 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>9/13/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Olivet</u>		
23d. LOCATION (City or town) (County) (State) <u>St. Michaels, Md.</u>			24. FUNERAL DIRECTOR <u>MURICE E. NEUNAM &amp; SON, Easton, Md.</u>				
25a. REC'D BY REGISTRAR DATE <u>SEP 13 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12993

12998

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWCOMB</u>		c. LENGTH OF STAY IN 1b <u>11 hours</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWCOMB</u>		d. STREET ADDRESS <u>-</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Levin</u> Middle <u>Gus</u> Last <u>Kilmon</u>		4 DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>AUG 31, 1904</u>
9 AGE (In years last birthday) <u>63</u> yrs		10. FUNERAL 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. U.S. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>	
11 BIRTHPLACE (County & State or foreign country) <u>TALBOT COUNTY, MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEVIN GUS KILMON, SR.</u>		14. MOTHER'S MAIDEN NAME <u>SARAH C. LARRIMORE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>21520-0853</u>	
17. INFORMANT <u>FRANKLIN R. KILMON, NEWCOMB, MD</u>		Address <u>NEWCOMB, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>reluctant obstructive pneumonia</u> <u>1621</u> DUE TO (b) <u>Massive bronchiogenic ca</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>most</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cachexia</u>		19 WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-54</u> , 19 <u>  </u> to <u>9-28</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>9-28</u> , 19 <u>67</u> and that death occurred at <u>1130</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Guy M. Reeser</u>		22b. DATE SIGNED <u>9-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Guy M. Reeser</u>		22d. ADDRESS <u>St. Michaels Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT 30, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>OLIVET CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>ST. MICHAELS, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>Harold E. Leonard</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>St. Michaels Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12999

12999

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN TB <b>2 days 9 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>215 N. Locust St.</b>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First <b>ERIC</b> Middle <b>MATZEIT</b> Last <b>MATZEIT</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>2</b> Year <b>1967</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-10</b>	9. AGE (In years last birthday) <b>56</b> yrs	IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min <b>56</b>		IF UNDER 24 HRS Hours <b>56</b> Min <b>56</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>barber</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Heinrich Matzeit</b>				14. MOTHER'S MAIDEN NAME <b>Lena</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-01-8149</b>		17. INFORMANT Address <b>Mrs. Mary A. Matzeit Easton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Colon</b> 12000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>TYR</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>TYR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-31</b> , 19 <b>67</b> to <b>9-2</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>9-2</b> , 19 <b>67</b> , and that death occurred at <b>8:30</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Harry M. Walsh, M.D.</b>				22b. DATE SIGNED <b>9-8-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Harry M. Walsh, M.D.</b>	
22d. ADDRESS <b>Easton, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>9/4/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill</b>		23d. LOCATION (City or Town) (County) (State) <b>Easton, Talbot, Md.</b>	
24. FUNERAL DIRECTOR <b>Tom D. Hovarian</b>				25a. REC'D BY REGISTRAR <b>SEP 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

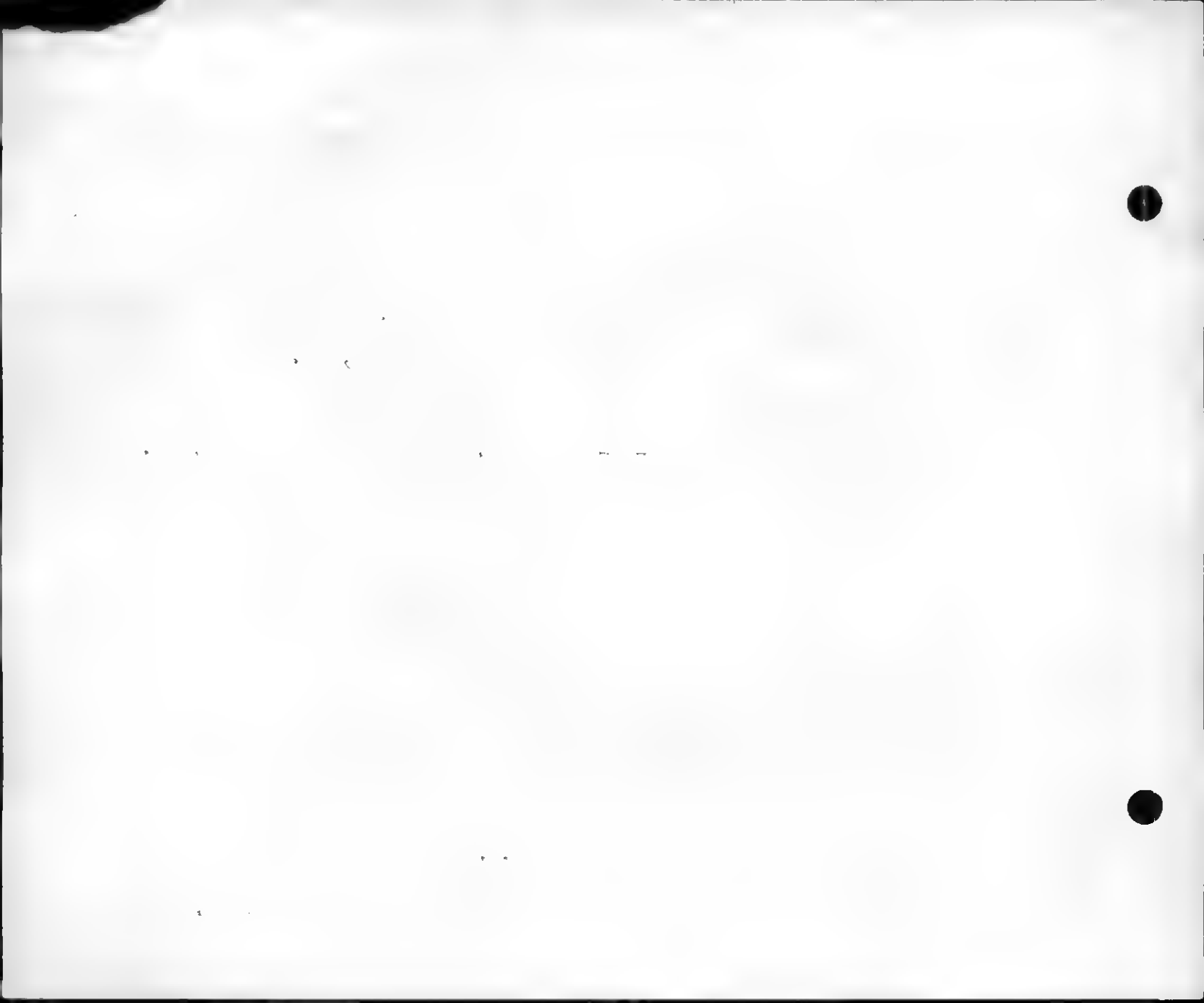
CERTIFICATE OF DEATH

12995

13400

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN TB <u>13 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		d. STREET ADDRESS <u>Box 14</u>	
3 NAME OF DECEASED (Type or print) First <u>Gustav</u> Middle <u>Mende</u> Last <u>Mende</u>		4 DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>March 16, 1893</u>
9 AGE (In years less birthday) <u>74</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) <u>St. Louis, Mo.</u>	
12 CITIZEN OF WHAT COUNTRY <u>USA</u>		13 FATHER'S NAME <u>Maxmillian Mende</u>	
14 MOTHER'S MAIDEN NAME <u>Helene Nette</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16 SOCIAL SECURITY NO. <u>217-36-1426</u>		17 INFORMANT Address <u>Mrs. Gustav Mende, Cordova, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u> <u>199.2</u> DUE TO (b) <u>CA. COLON + L KIDNEY WITH</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>HEPATIC + PULMONARY METASTASES</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>1 YEAR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-25, 1967</u> to <u>9-2, 1967</u> , that (I) (we) last saw the deceased alive on <u>9-2, 1967</u> , and that death occurred at <u>7 AM</u> , from causes and on the date stated above			
22a SIGNATURE <u>John Knud-Hansen</u>		22b DATE SIGNED <u>9/5/67</u>	
22c PHYSICIAN'S NAME (Type) <u>John Knud-Hansen</u>		22d ADDRESS <u>Easton, Maryland</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>9/5/1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial Park</u>	23d LOCATION (City or Town) (County) (State) <u>Easton, Md.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Maurice Newman &amp; Son Easton Md.</u>		25a REC'D BY REGISTRAR DATE <u>SEP 7 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

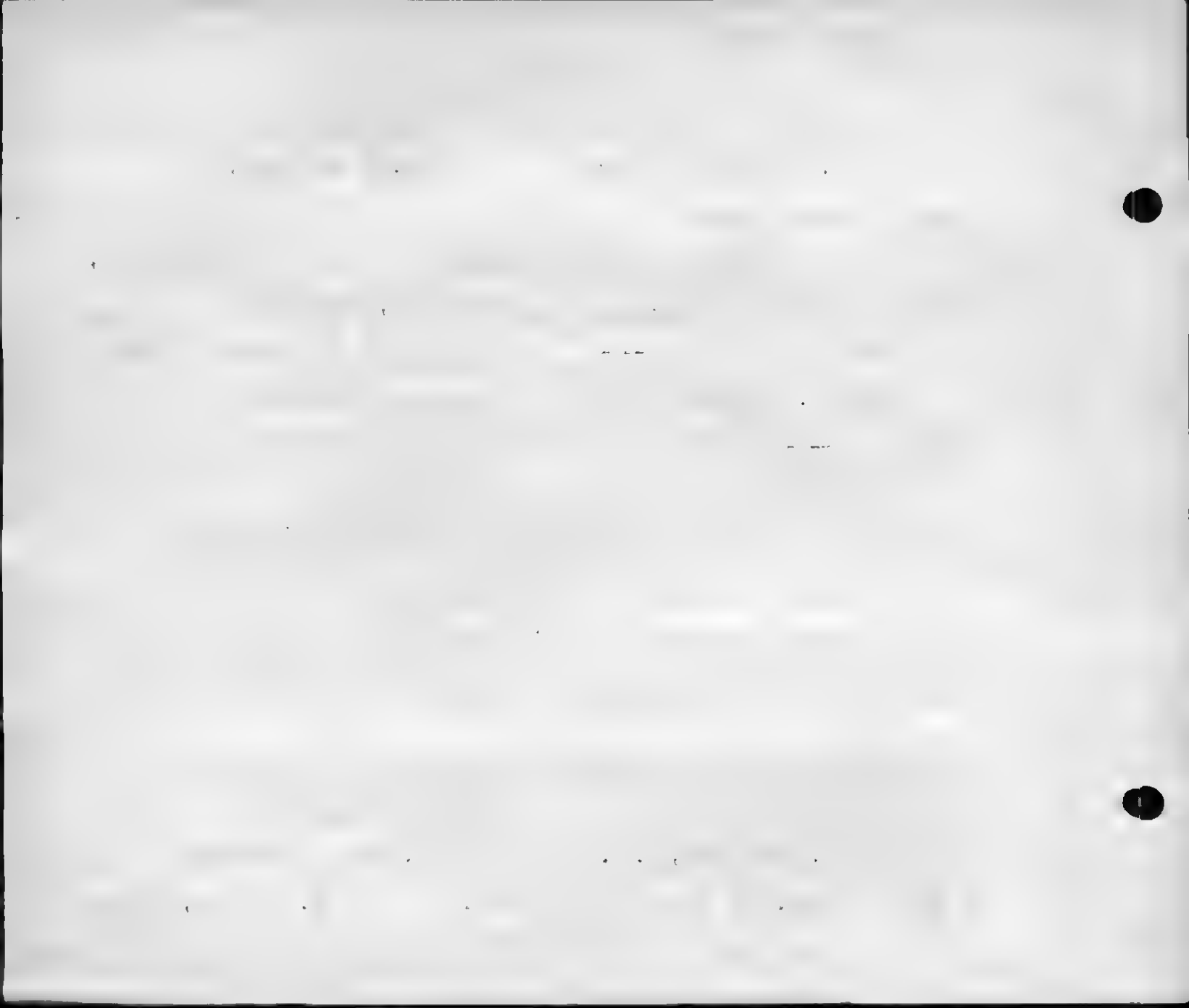
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12896

43001

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels</b> d. STREET ADDRESS <b>Royal Oak,</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - St. Michaels</b>			c. LENGTH OF STAY IN lb <b>4 yrs</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rio Vista Nursing Home</b>					
3. NAME OF DECEASED (Type or print) <b>CLARA FRANKEM PERKINS</b>			4. DATE OF DEATH <b>September 20, 1967</b>		
5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH <b>September 21, 1879</b>		
9. AGE (In years last birthday) <b>88 yrs.</b>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		
10a. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Harrisburg, Pennsylvania</b>		
12. CITIZEN OF WHAT COUNTRY <b>USA</b>			13. FATHER'S NAME <b>Edward F. Frankem</b>		
14. MOTHER'S MAIDEN NAME <b>Sarah Ann Spousler</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>---</b>			17. INFORMANT <b>Records - Rio Vista Nursing Home</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Arteriosclerotic Cardiovascular Dis 10 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cholelithiasis - Cholecystitis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cholelithiasis - Cholecystitis</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (his hospital) attended the deceased from <b>6-23</b> 19 <b>58</b> to <b>9-20</b> 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>9-19</b> 19 <b>67</b> and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>R. Lane Wroth</b>					
22b. DATE SIGNED <b>9-21-67</b>					
22c. PHYSICIAN'S NAME (Type) <b>R. LANE WROTH, M. D.</b>					
22d. ADDRESS <b>St. Michaels, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 23, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>	
23d. LOCATION (City, town or county) <b>St. Michaels, Maryland</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Leonard, St. Michaels Md</b>					
25. REC'D BY REGISTRAR <b>SEP 26 1967</b>					
25b. REGISTRAR'S SIGNATURE					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

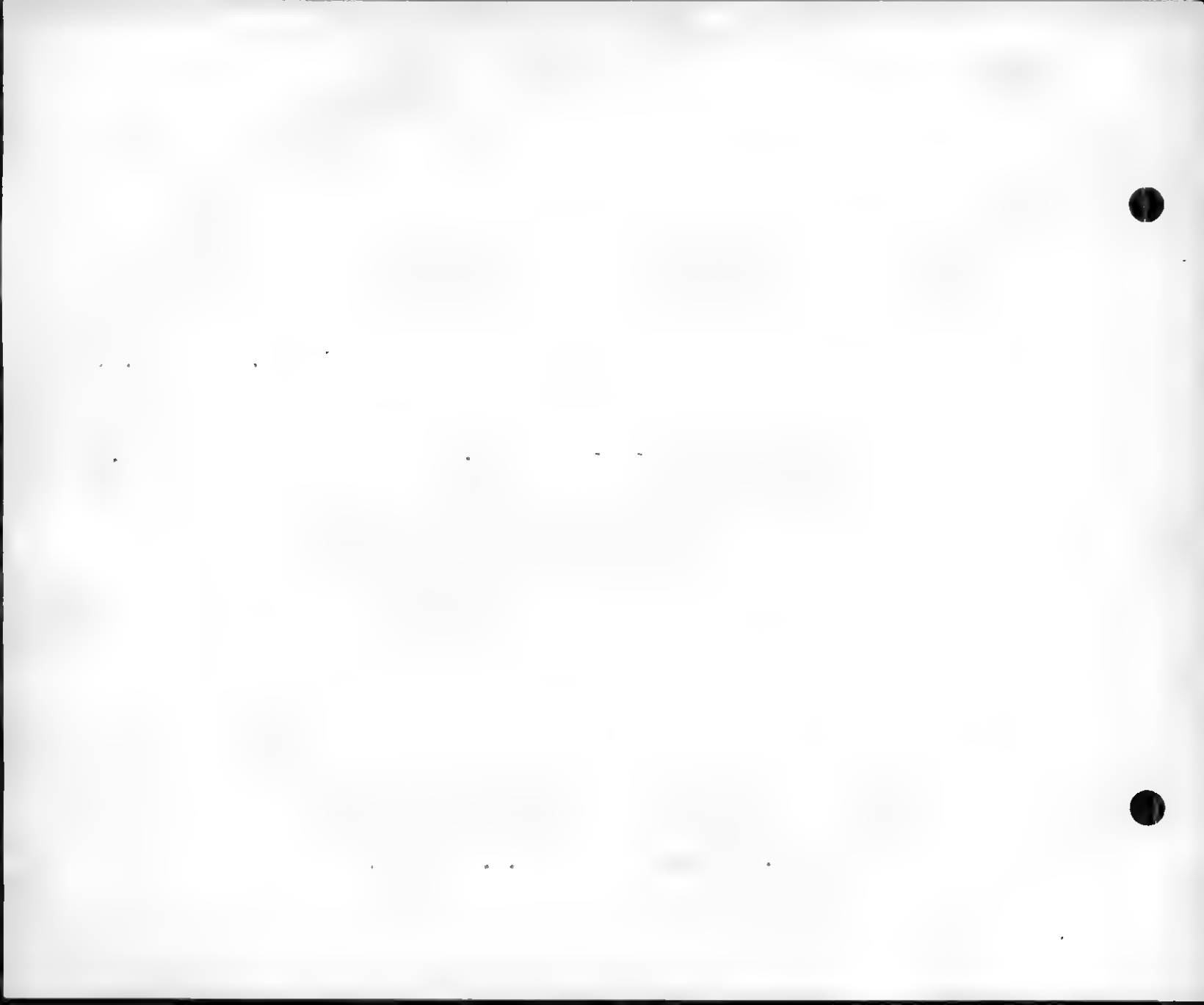
13002

1299

1 PLACE OF DEATH a. COUNTY <u>Albany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY in 1b <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Goldsboro, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Pinder</u> Last <u>Pinder</u>				4. DATE OF DEATH <u>Sept</u> <u>21</u> 19 <u>67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/1902</u>		9. AGE (In years last birthday) yrs <u>65</u>	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Queen Anne's Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Steve Pinder</u>				14. MOTHER'S MAIDEN NAME <u>Alice Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>213-24-1640</u>		17. INFORMANT Address <u>Mrs. Mary Hines Goldsboro, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cyanide D Bleeder Proctitis</u> DUE TO (b) <u>C Metastases D Pelvic Nerve</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-13</u> , 19 <u>67</u> , to <u>9-21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-21</u> , 19 <u>67</u> , and that death occurred at <u>5:44</u> M, from causes and on the date stated above.							
21a. SIGNATURE <u>John N. Robinson</u>				21b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		21c. DATE SIGNED <u>9-22-67</u>	
21d. PHYSICIAN'S NAME (Type) <u>John N. Robinson</u>				21e. ADDRESS <u>M.D. Easton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/24/1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Roseville Cemetery</u>		22d. LOCATION (City or Town) (County) (State) <u>Near Prices Queen Anne's Co. Md.</u>	
23. FUNERAL DIRECTOR <u>Samuel D. Dally</u>				24. ADDRESS <u>Chesapeake, Md.</u>			
25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>				25b. REGISTRAR'S SIGNATURE <u>John N. Robinson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

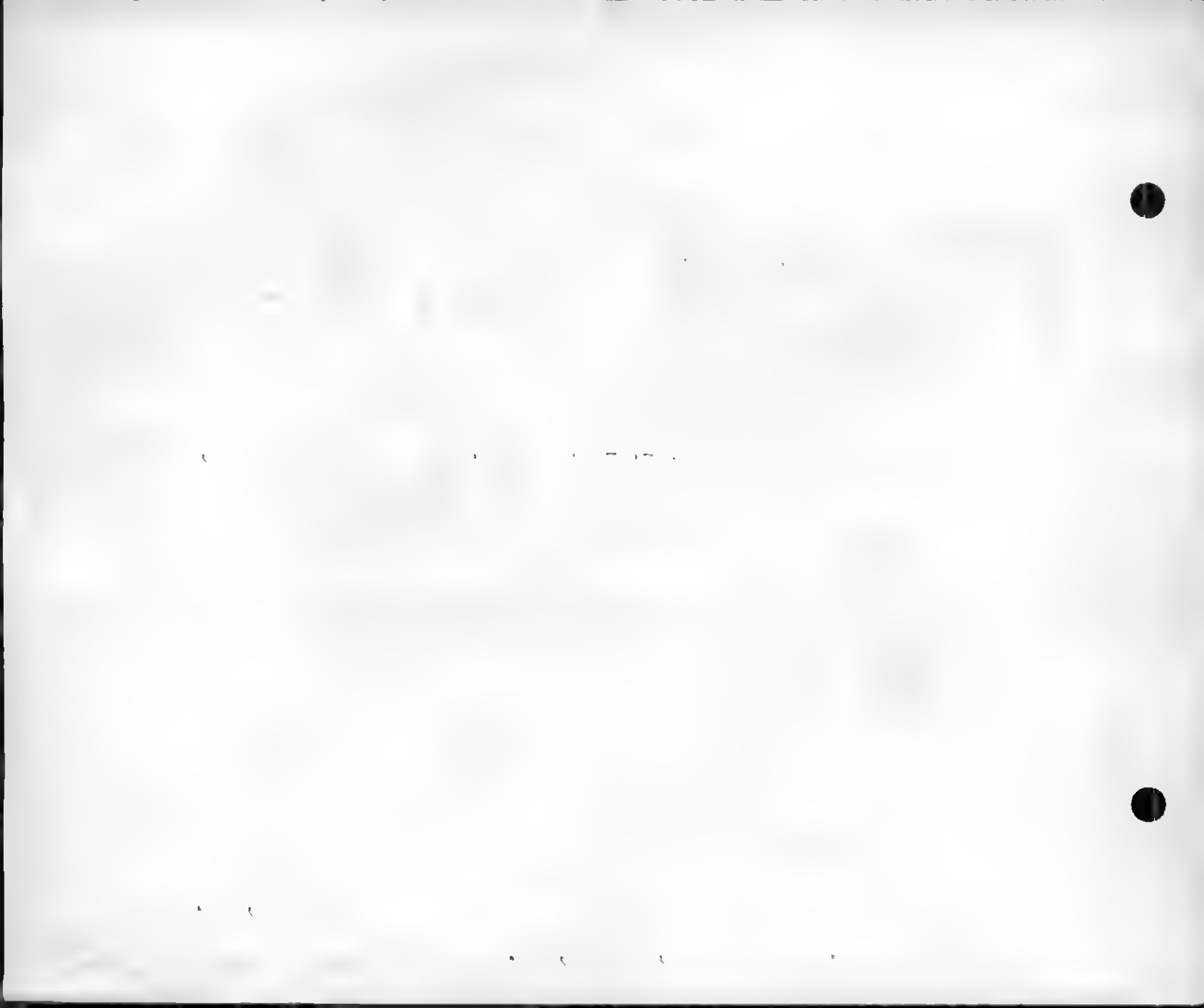
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

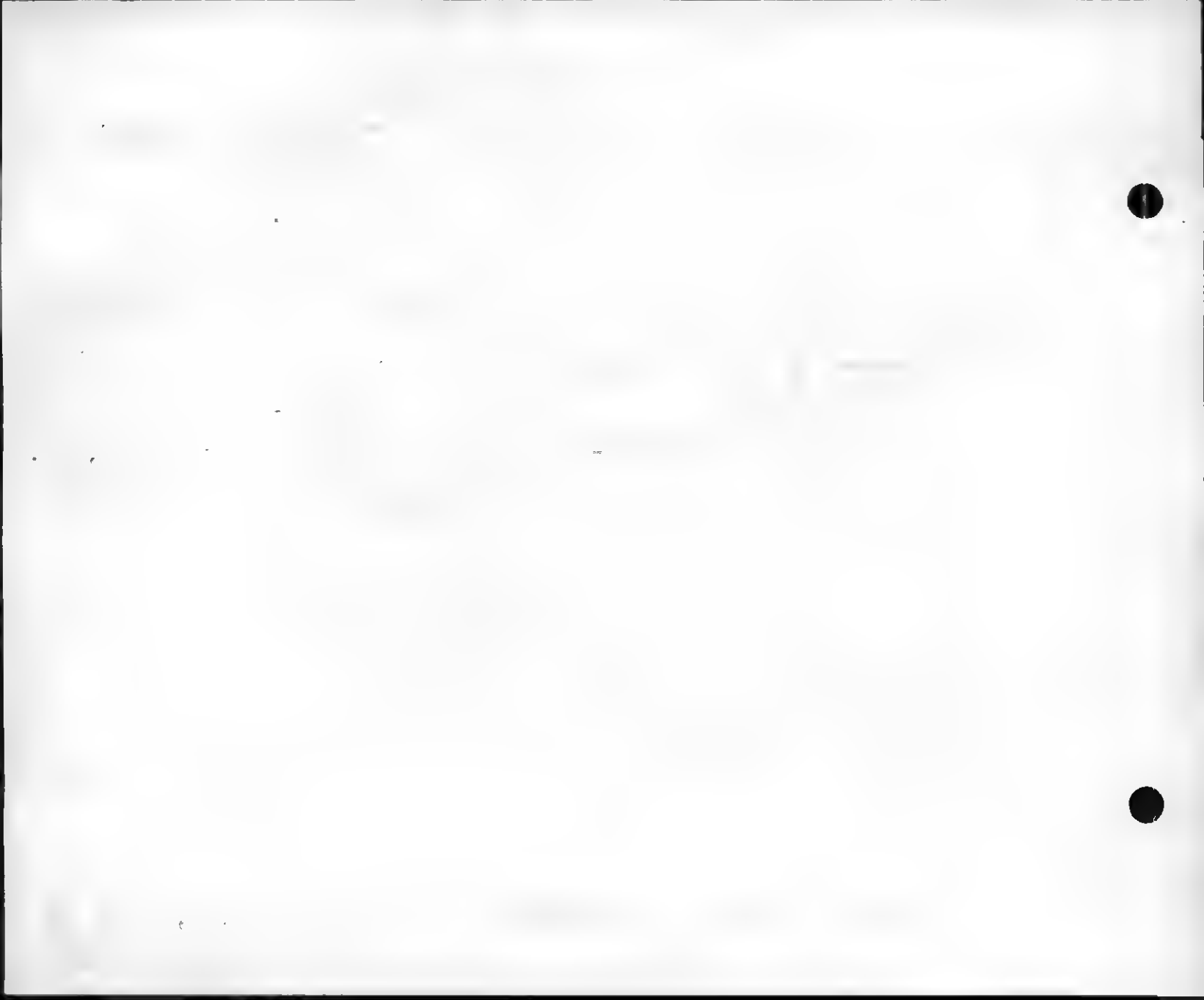
12993

13003

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CONROVA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CONROVA</b>	
c. LENGTH OF STAY IN 1b <b>23 years</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marquerite Milby</b> First <b>ROE</b> Middle Last		4. DATE OF DEATH <b>Sept. 9</b> 19 <b>67</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 4, 1896</b> 70 yrs.
9. AGE (In years lost in day) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Queen Anne Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Franklin Milby</b>		14. MOTHER'S MAIDEN NAME <b>Mary Andrews</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-16-9015</b>	
17. INFORMANT <b>Mrs. Jervis Cooke, Newark, Delaware</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>+ 201</b> DUE TO <b>Coronary artery disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN DEATH AND DISCOVERY <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Aug</b>	20f. (City or town) (County) (State) <b>X3 May 1967</b>
21. I certify that (I) (this hospital) attended the deceased from <b>May 15 1967</b> to <b>May 19 1967</b> that (I) (we) last saw the deceased alive on <b>May 15 1967</b> , and that death occurred at <b>11</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Kurt Lederer</b> M.D.		22b. DATE SIGNED <b>9-9-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>KURT LEDERER</b>		22d. ADDRESS <b>QUEEN ANNE MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/9/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>	23d. LOCATION (City or town) (County) (State) <b>Easton, Md.</b>
24. FUNERAL DIRECTOR <b>MURICE E. NEUNAM &amp; SON, Easton, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Sunset Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Marie Shanahan</u> First Middle Last		4. DATE OF DEATH <u>9 26 1967</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-30-1894</u>
9. AGE (In years) <u>72</u> 1/2 day yrs		10. IF UNDER 1 YEAR Months Days	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13. FATHER'S NAME <u>Andrew Coyle</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>114-07-2751</u>	
17. INFORMANT <u>Dorothy Shanahan</u>		Address <u>Greensboro, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> A.I.X. OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } OUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>&lt; 24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> , 19 <u>67</u> , to <u>9/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/26</u> , 19 <u>67</u> , and that death occurred at <u>7:00</u> P.M., from causes and on the date stated above			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-30-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		23d. LOCATION (City or Town) (County) (State) <u>Greensboro, Maryland</u>	
24. FUNERAL DIRECTOR <u>J. E. Boulain, Greensboro, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that Page 4 may be retained by the hospital or attending physician.

TO FU  
direct

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

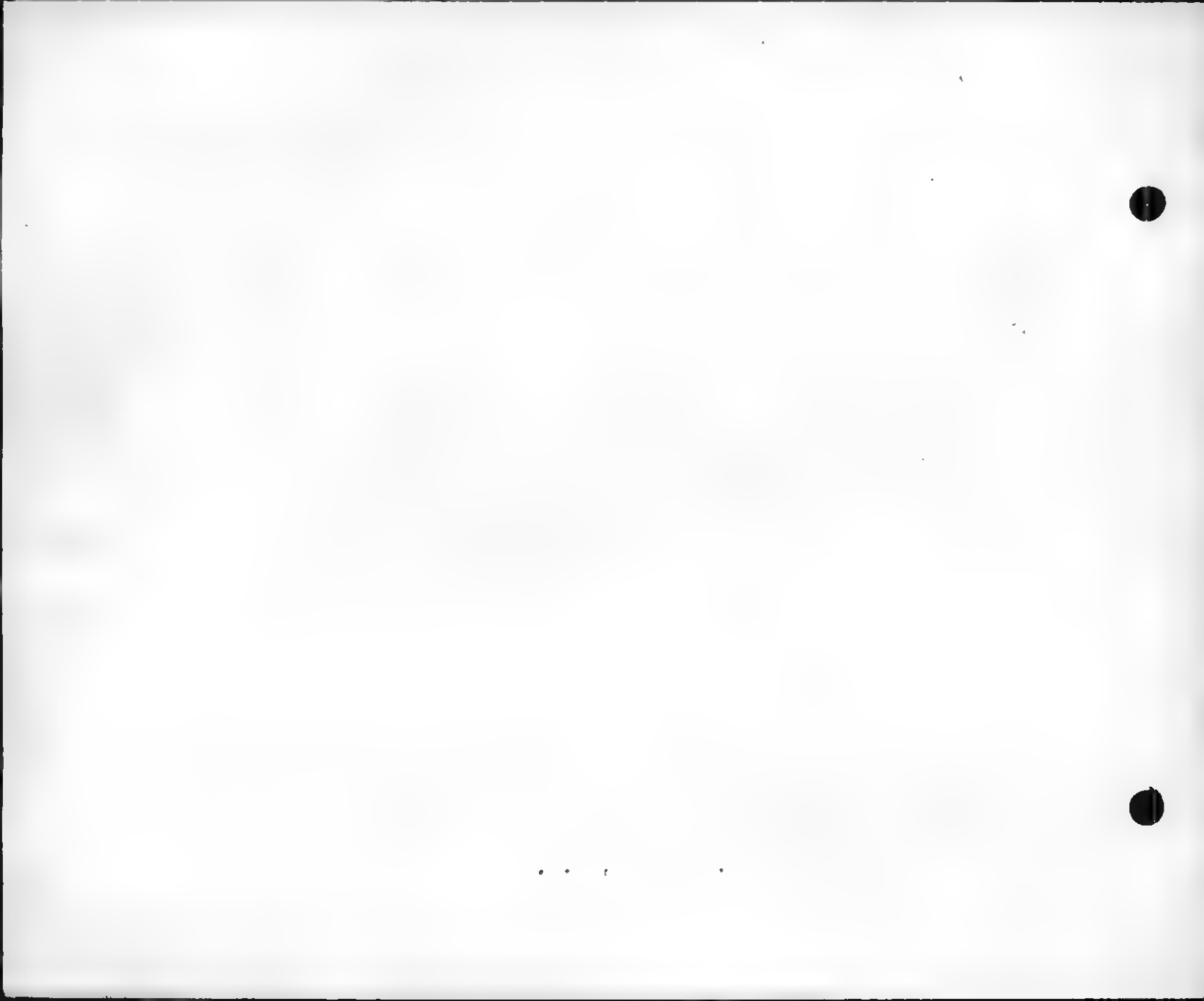
# I

Brother  
 Robert Stauger  
 Williamsburg 3425

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
 Items #2d & 9 filed 9/25/07 ph  
 CERTIFICATE OF DEATH

13005

1 PLACE OF BIRTH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b COUNTY <u>TALBOT</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c LENGTH OF STAY IN 1b <u>11</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crematorium Hosp.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Nathan Slaughter</u>		4 DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>1967</u>	
5 SEX <u>MALE</u>		6 COLOR OR RACE <u>NEGRO</u>	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11-27-1901</u>	
9 AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b KIND OF BUSINESS OR INDUSTRY <u>MILL (GRAIN)</u>	
11 BIRTHPLACE (County & State or foreign country) <u>TALBOT - MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>NATHAN SLAUGHTER</u>		14. MOTHER'S MAIDEN NAME <u>MARY FRANCIS MURRAY</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>219-01-0727</u>	
17. INFORMANT <u>ROBERT SLAUGHTER - TAMPE, MD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> 446 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>arteriosclerotic renal disease</u> DUE TO (c) <u>many years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12 Sep, 1967</u> to <u>17 Sep, 1967</u> that (I) (we) last saw the deceased alive on <u>9/17/67</u> and that death occurred at <u>10 P</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Stephen P. Carnery</u> M.D.		22b DATE SIGNED <u>9-18-67</u>	
22c PHYSICIAN'S NAME (Type) <u>Stephen P. Carnery, M.D.</u>		22d ADDRESS <u>Easton, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>9-21-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Truants town</u>		23d LOCATION (City or Town) (County) (State) <u>Easton Talbot MD</u>	
24. FUNERAL DIRECTOR <u>Barbara D. Whill</u>		25a REC'D BY REGISTRAR DATE <u>SEP 20 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

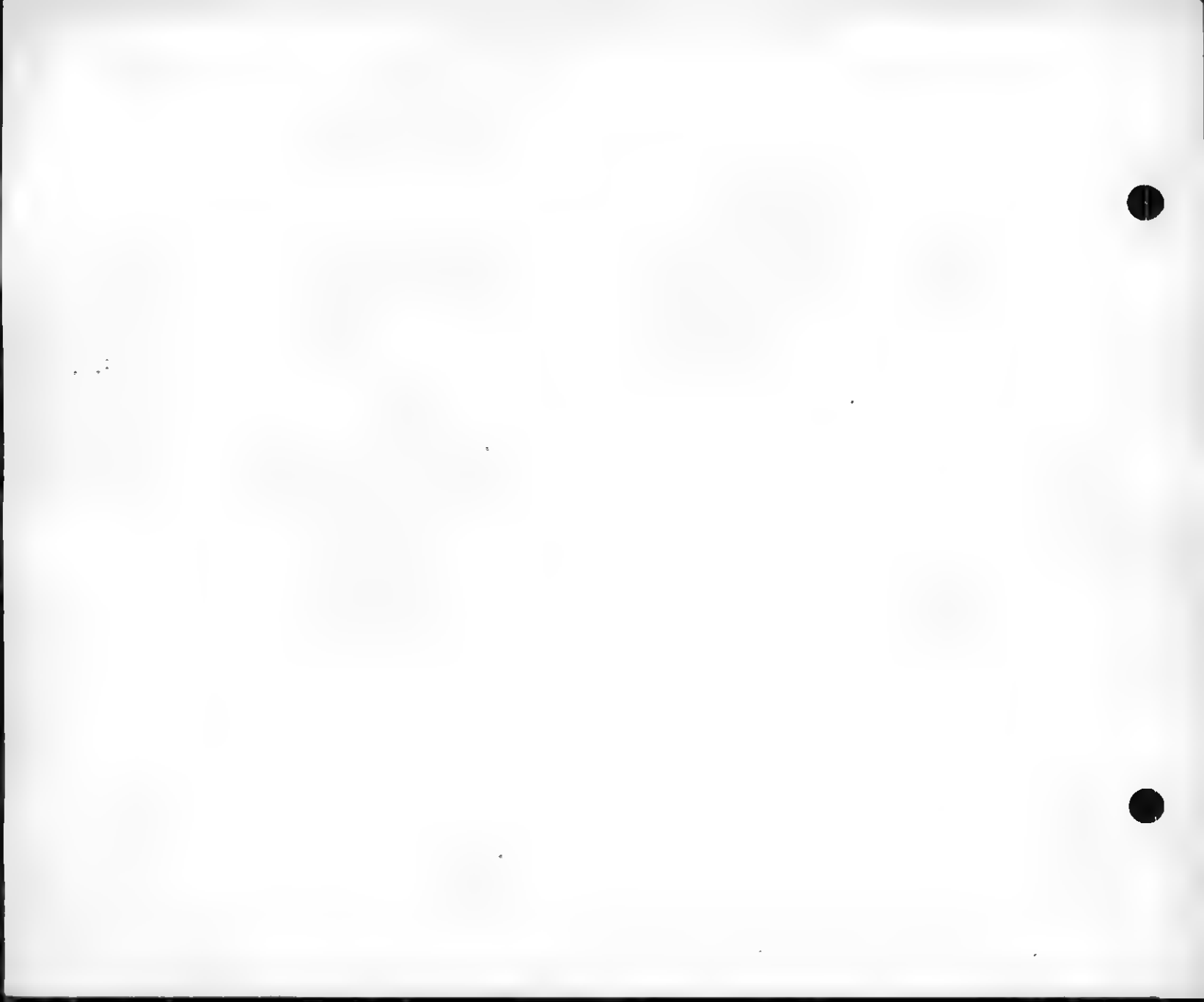
VR A15 (4)  
25M 1/67

13002

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2 infor, taken from birth cert. pn  
CERTIFICATE OF DEATH

14514

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Caroli</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>10 min</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. STREET ADDRESS <b>401 Central Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>BABY GIRL Shoaf</b>		DATE OF DEATH <b>9 8 1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/8/67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>Easton, Md. Memorial Hospital</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Joseph A. Shoaf</b>		14. MOTHER'S MAIDEN NAME <b>Mary White</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs. Mary Shoaf</b>		Address <b>Ridgley, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Immature Infant</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>11:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>E. D. Hardy</b>		22b. DATED <b>10/9/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. D. Hardy</b>		22d. ADDRESS <b>M. D. Easton, Maryland</b>	
23a. BURIAL CREMATION <b>Incineration</b>	23b. DATE THEREOF <b>9/11/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Hospital</b>	23d. LOCATION (City or town) (County) (State) <b>Easton, Maryland</b>
24. FUNERAL DIRECTOR <b>Memorial Hospital, Easton, Maryland</b>		25a. REC'D BY REGISTRAR <b>OCT 10 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13006

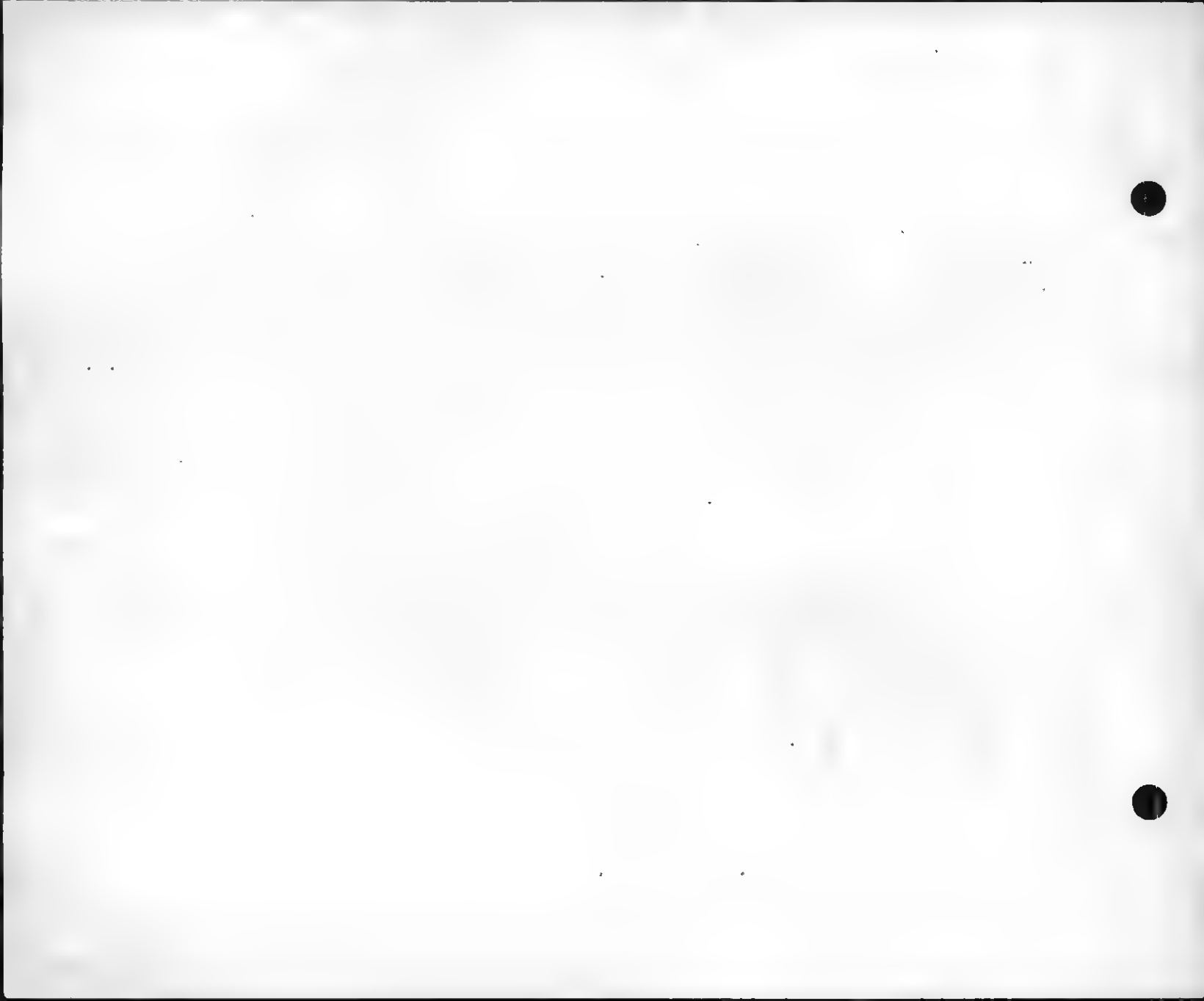
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13006

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN TB <u>4 hours</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>			d. STREET ADDRESS <u>R.F.D. # 2 - Box 102</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>LEROY</u> First <u>White</u> Middle <u>SPRINGS</u> Last			4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1967</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 16, 1935</u>	9. AGE (In years lost birthday) yrs <u>31</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Jacksonville, Florida</u>	
13. FATHER'S NAME <u>Matthew White</u>			14. MOTHER'S MAIDEN NAME <u>Florida Mae Springs</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>0</u>		16. SOCIAL SECURITY NO. <u>220-32-8396</u>		17. INFORMANT Address <u>Florida Mae Ross, Preston, Md., RFD #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Irreversible Shock From External Hemorrhage</u> DUE TO (b) <u>Also possible internal hemorrhage</u> DUE TO (c) <u>Compound Comminuted fracture humerus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>6 hours</u> <u>6 hours</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>? Alcoholism</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Hit &amp; run Route 318 between Preston &amp; Federalsburg</u>			
20c. TIME OF INJURY Month Day Year hour a.m. <u>9</u> p.m. <u>19</u> <u>9/9.67</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>As above</u>		20f. (City or town) (County) (State) <u>Federalsburg Caroline Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Harold B. Plummer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Preston Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sent. 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jonestown Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Near Preston, Maryland</u>
24. FUNERAL DIRECTOR <u>Trampton Funeral Home Federalsburg Maryland</u>			25a. REC'D BY REGISTRAR DATE <u>SEP 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

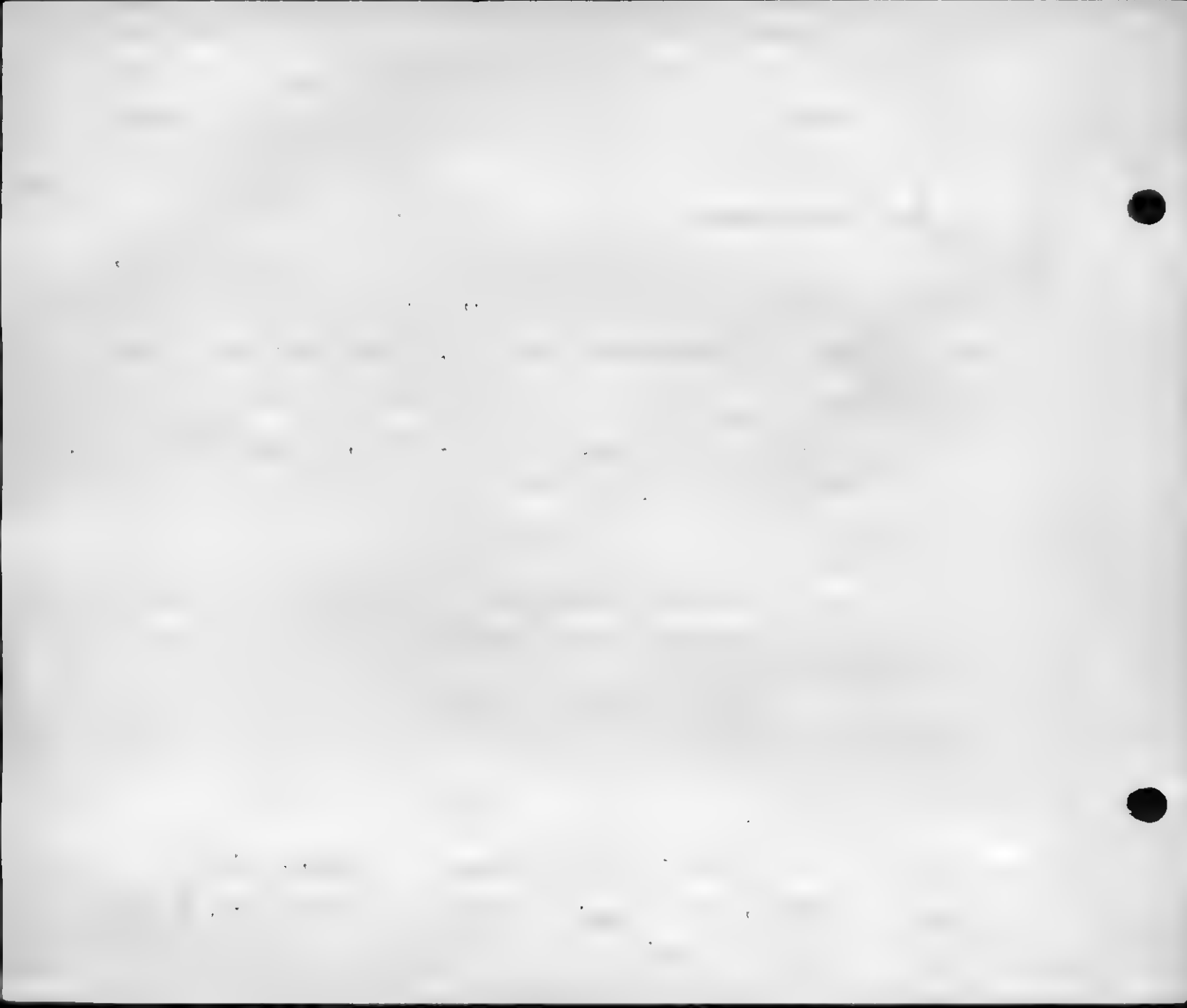
22. DATE SIGNED

9/12/67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN IL <b>3 yrs</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Talbot</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton Towson</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Home for Aged Women</b>						d. STREET ADDRESS <b>Eudowood Sanatorium</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>INA HIGGINS STANGE</b>		4. DATE OF DEATH <b>September 11, 1967</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>Oct 4, 1887</b>	
9. AGE (In years last birthday) <b>79</b>		10. AGE (In years last birthday) <b>79</b>		11. BIRTHPLACE (County & State, or foreign country) <b>St. Michaels, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Daniel Higgins</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Frampton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-32-4150</b>		17. INFORMANT <b>Albert B. Stange, 4501 Mainfield, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>334x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Hemorrhagic Cystitis &amp; Bladder Carcinoma</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... <b>Aug 11, 1967</b> ... to... <b>Sept 11, 1967</b> ... that (I) (we) last saw the deceased alive on... <b>Sept 11, 1967</b> ... and that death occurred at <b>3:45 PM</b> ... from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert M. McDonald</b>						22b. DATE SIGNED <b>9/11/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert M. McDonald, M.D.</b>		22d. ADDRESS <b>Easton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept 14, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Harrison C. Leonard, St. Michaels, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 18 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>											



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

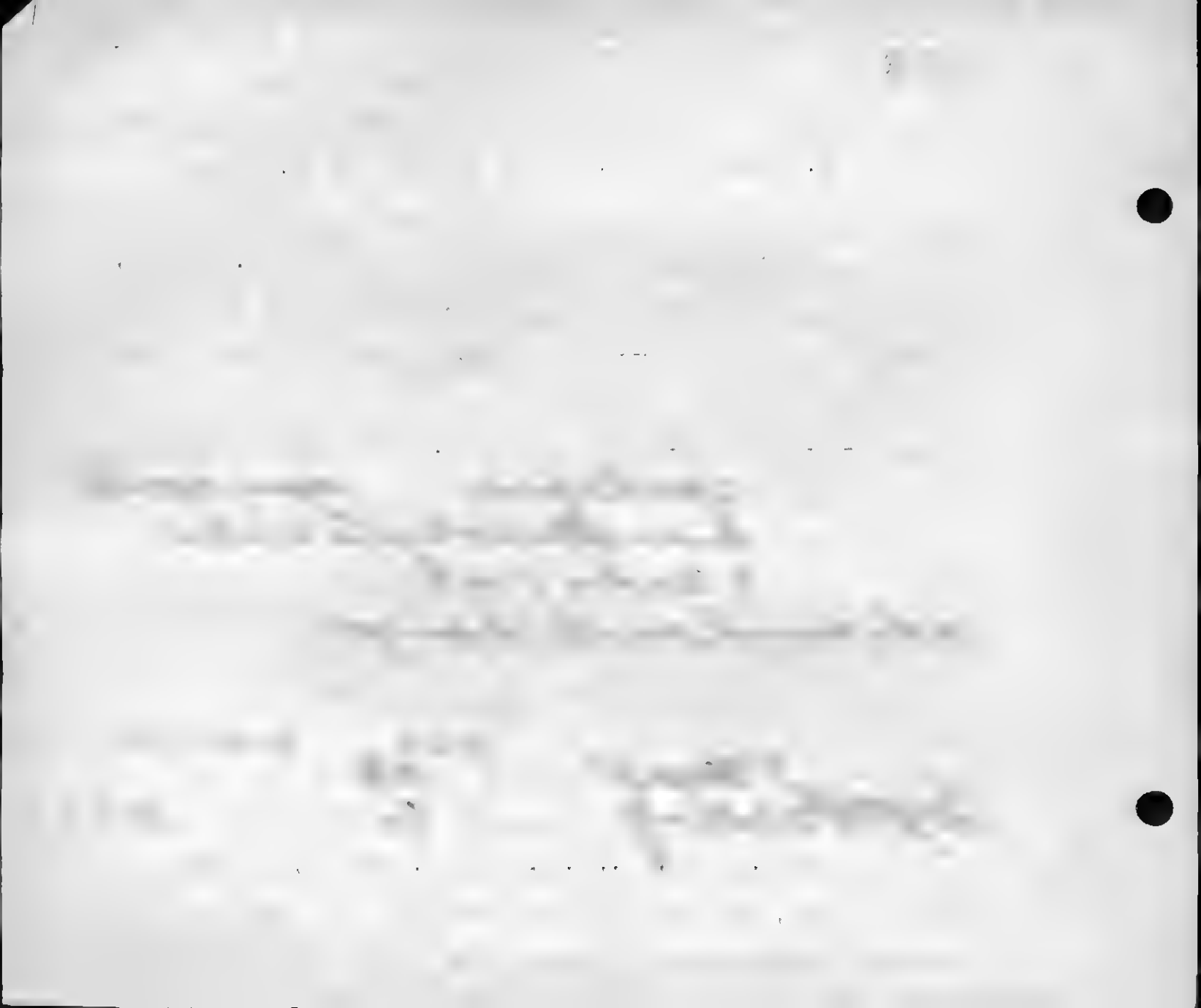
## CERTIFICATE OF DEATH

14508

14519

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Talbot</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - St. Michaels</u> <span style="float: right;">Life</span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) -----				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Talbot</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - St. Michaels</u> d. STREET ADDRESS -----			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <u>WILLIAM JAMES THOMAS</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>September 30, 19 67</u>				
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>C</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>Aug 18, 1870</u>		<b>9. AGE</b> (In years last birthday) <u>97 yrs</u>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> ---		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>St. Michaels, Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Wilson Thomas</u>					
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary ?</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>					
<b>16. SOCIAL SECURITY NO.</b> <u>218-30-1190</u>		<b>17. INFORMANT</b> <u>William H. Thomas, St. Michaels, Maryland</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>cochepia</u> DUE TO <u>severe stroke cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>&amp; cardio vas d.</u> DUE TO (c) <u>cardio vas d.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>advanced senile changes</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>1955</u>			
<b>20f. (City or town)</b> <u>St. Michaels, Maryland</u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>9-30-1967</u> <b>to</b> <u>9-30-67</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>9-30-1967</u> , <b>and that death occurred</b> <u>10-3-67</u> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Guy M. Reeser Jr.</u>		<b>22b. DATE SIGNED</b> <u>10-3-67</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>GUY M. REESER, Jr., M. D.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Oct 5, 1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Thomas Memorial Cemetery</u>			
<b>23d. LOCATION (City, town or county)</b> <u>St. Michaels, Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harmon E. Leonard, St. Michaels, Md.</u>					
<b>25a. REC'D BY REGISTRAR</b> <u>DATE OCT 3 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles J...</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

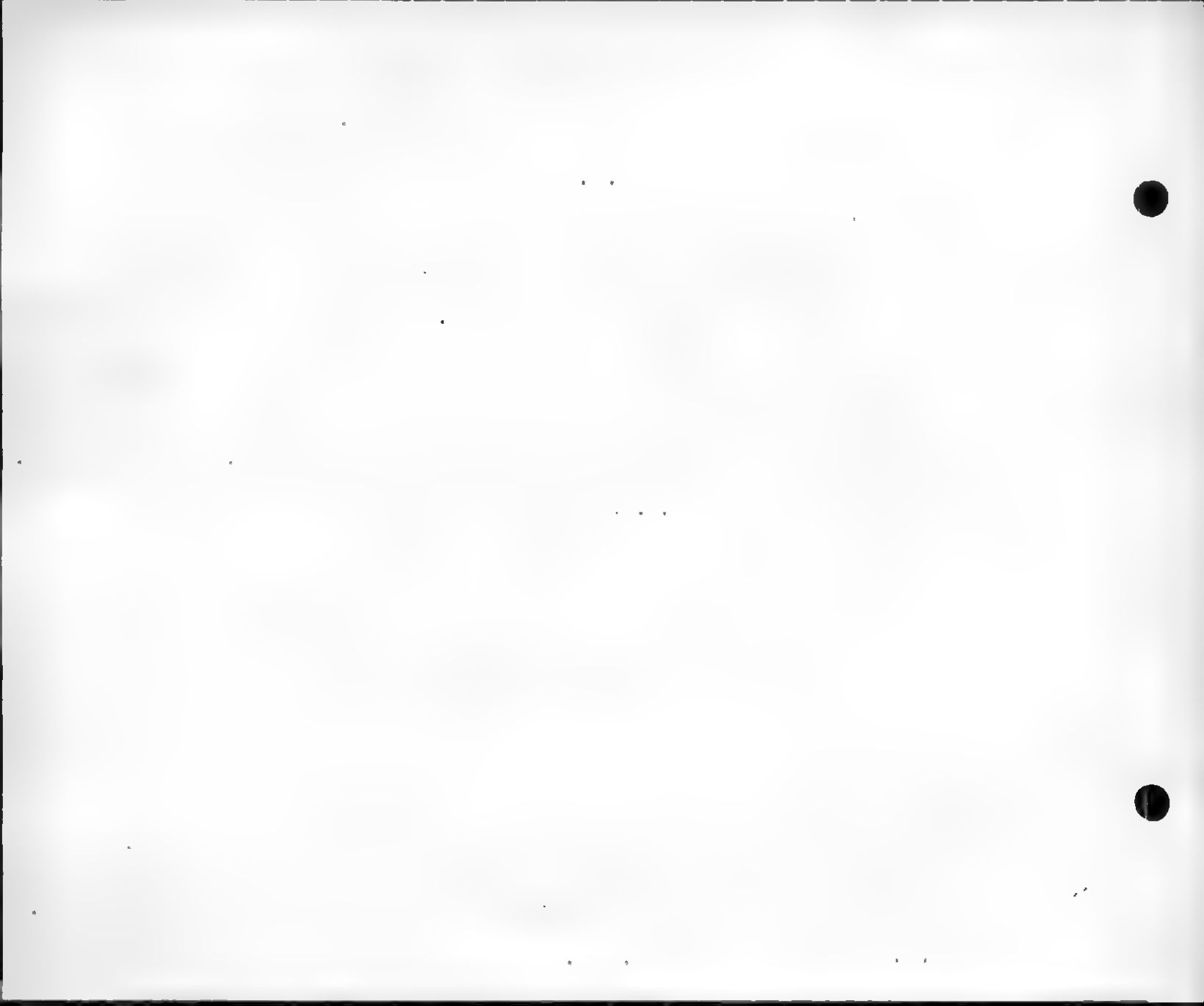
13004  
12 10 a.m.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #7 File #G393 9/27/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13008

1 PLACE OF DEATH a COUNTY <b>Talbot</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c LENGTH OF STAY N 1b <b>D.O.A</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Md.</b> b COUNTY <b>Talbot</b>		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>McDaniel</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial</b>				d STREET ADDRESS		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Earl Samuel Turner</b>		4 DATE OF DEATH Month <b>Sept</b> Day <b>16</b> Year <b>1967</b>		5 SEX <b>Male</b>		6 COLOR OR RACE <b>Negro</b>	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>Nov. 7, 1929</b>		9 AGE (In years last birthday) <b>37</b> yrs		10 IF UNDER 1 YEAR F UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Theophilus Murray</b>				14 MOTHER'S MAIDEN NAME <b>Catherine Turner</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <b>yes</b>		16 SOCIAL SECURITY NO <b>220-26-3989</b>		17 INFORMANT Address <b>Leonard Palmer St. Michaels, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>G.S.W. Chest</b> <b>781 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>shot during altercation in bar</b>					
20c TIME OF INJURY Month, Day, Year Hour <b>11:30</b> <b>30X</b> p.m. <b>9-16</b> 19 <b>67</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>bar</b>		20f (City or town) (County) (State) <b>St Michaels Talbot Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Louis O Welty</b> EXAMINER'S NAME (Type) <b>Welty</b>		M D <b>for</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>9-19-67</b> Address (Street, city, town or county)	
23a BURIAL CREMATION, (Specify) <b>burial</b>		23b DATE THEREOF <b>9-22-67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Claiborne</b>		23d LOCATION (city or town) (County) (State) <b>Claiborne Talbot Md.</b>	
24 FUNERAL DIRECTOR ADDRESS <b>B.L. Dashiell Easton, Md.</b>				25a REC'D BY REGISTRAR DATE <b>SEP 20 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

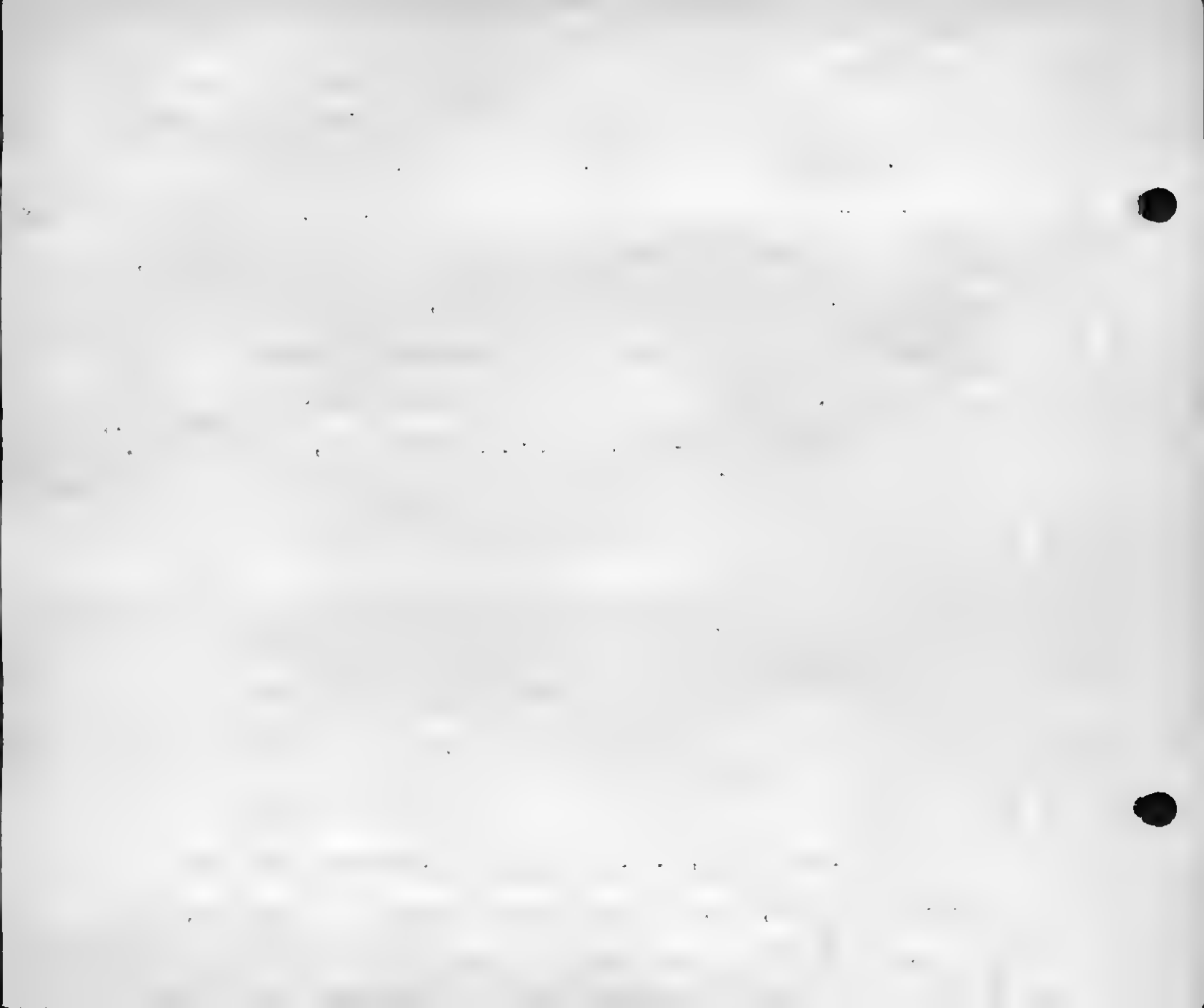
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13005 Item#1d Film #G395 10/27/67 pu											
CERTIFICATE OF DEATH											
13009											
1. PLACE OF DEATH a. COUNTY <u>Tolbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>2 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>520 N. Washington St.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dor.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hurtlock</u> d. STREET ADDRESS <u>Main</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Maudie</u> First <u>Ellis</u> Middle <u>Venzables</u> Last						4. DATE OF DEATH <u>9</u> Month <u>18</u> Day <u>1967</u> Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/2/1896</u>		9. AGE (in years last birthday) <u>71</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owned &amp; operated a Rest Home</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Ellis</u>						14. MOTHER'S MAIDEN NAME <u>Lizzie Spear</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Lloyd Christopher, Easton, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> 112X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Carcinoma of the endometrium</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis enlarged varicosities both legs</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 mos</u> <u>3 yrs</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> , 19 <u>53</u> , to <u>9-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/20/67</u> , 19 <u>67</u> , and that death occurred at <u>5A M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Harold B. Plummer</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-19-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Harold B. Plummer M.D.</u>						22d. ADDRESS <u>Preston Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Firemans</u>				23d. LOCATION (City, town or county) (State) <u>Sharptown, Md</u>			
24. FUNERAL DIRECTOR <u>Ruth S. Nulloyghy, East New Market, Md</u>						25a. REC'D BY REGISTRAR <u>SEP 25 1967</u>		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
20M 563

<div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>13006</b> </div> <div> <b>13010</b> </div> </div> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Talbot</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>St. Michaels</b> c. LENGTH OF STAY IN 1b <b>9 mos.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>St. Michaels</b> d. STREET ADDRESS <b>Chestnut St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>EDWARD</b> Middle <b>NATHANIEL</b> Last <b>WATTS</b>					<b>4. DATE OF DEATH</b> <b>September 18, 1967</b> Month <b>September</b> Day <b>18</b> Year <b>1967</b>				
<b>5. SEX</b> <b>Male</b> <b>White</b> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Sept 13, 1902</b> <b>65 yrs.</b>					<b>9. AGE (In years last birthday)</b> <b>65 yrs.</b> <b>10. IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b> <b>11. IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Drugs</b>					<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Talbot County, Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>				
<b>13. FATHER'S NAME</b> <b>Charles D. Watts</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Annabelle Cooper</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW II</b> <b>16. SOCIAL SECURITY NO.</b> <b>160-03-9851 A</b>					<b>17. INFORMANT</b> <b>Mrs. Gertrude Watts, Baltimore, Md. 21212</b> <b>1022 Woodson Rd.,</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> (b) <b>Arteriosclerotic Cardiovascular Disease</b> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Emphysema</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____				
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. _____ p.m. _____					<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Sept 18, 1967</b> <b>to</b> <b>Sept 18, 1967</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Sept 18, 1967</b> <b>and that death occurred at</b> <b>5:12 M.</b> <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>R. Lane Wroth</b> <b>M.D.</b>					<b>22b. DATE SIGNED</b> <b>9-19-67</b>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>R. Lane Wroth, M. D.</b>					<b>22d. ADDRESS</b> <b>St. Michaels, Maryland</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>					<b>23b. DATE THEREOF</b> <b>Sept 21, 1967</b>				
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National Cemetery</b>					<b>23d. LOCATION (City, town or county)</b> <b>Baltimore, Maryland</b> <b>(State)</b> _____				
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Harison E. Leonard, St. Michaels Md.</b>					<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles J. [Signature]</b> <b>DATE</b> <b>SEP 21 1967</b>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13006

CERTIFICATE OF DEATH

13011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN TB <u>2 hr. 10 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Mac</u> Last <u>Willey</u>				4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 8, 1897</u>	9. AGE (in years last birthday) <u>69</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State or foreign country) <u>PARKTON, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY ENSOR</u>				14. MOTHER'S MAIDEN NAME <u>JENNY ELIZABETH HECK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>2A-09-0300</u>		17. INFORMANT <u>EDWARD WILLEY, ST. MICHAELS, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial infarction</u> DUE TO (b) <u>Small cell carcinoma of lung, 9 mm.</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day, Year Hour <u>  </u> o.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work No/While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>Sept 12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12 Sept</u> , 19 <u>67</u> , and that death occurred at <u>9 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>R. Lane Wroth</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>9-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. Lane Wroth</u>		22d. ADDRESS <u>St. Michaels, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>SEPT 15, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>St. Michaels, Md.</u>	
24. FUNERAL DIRECTOR <u>Harriett Leonard, St. Michaels</u>				25a. REC'D BY REGISTRAR <u>SEP 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

13008

**CERTIFICATE OF DEATH**

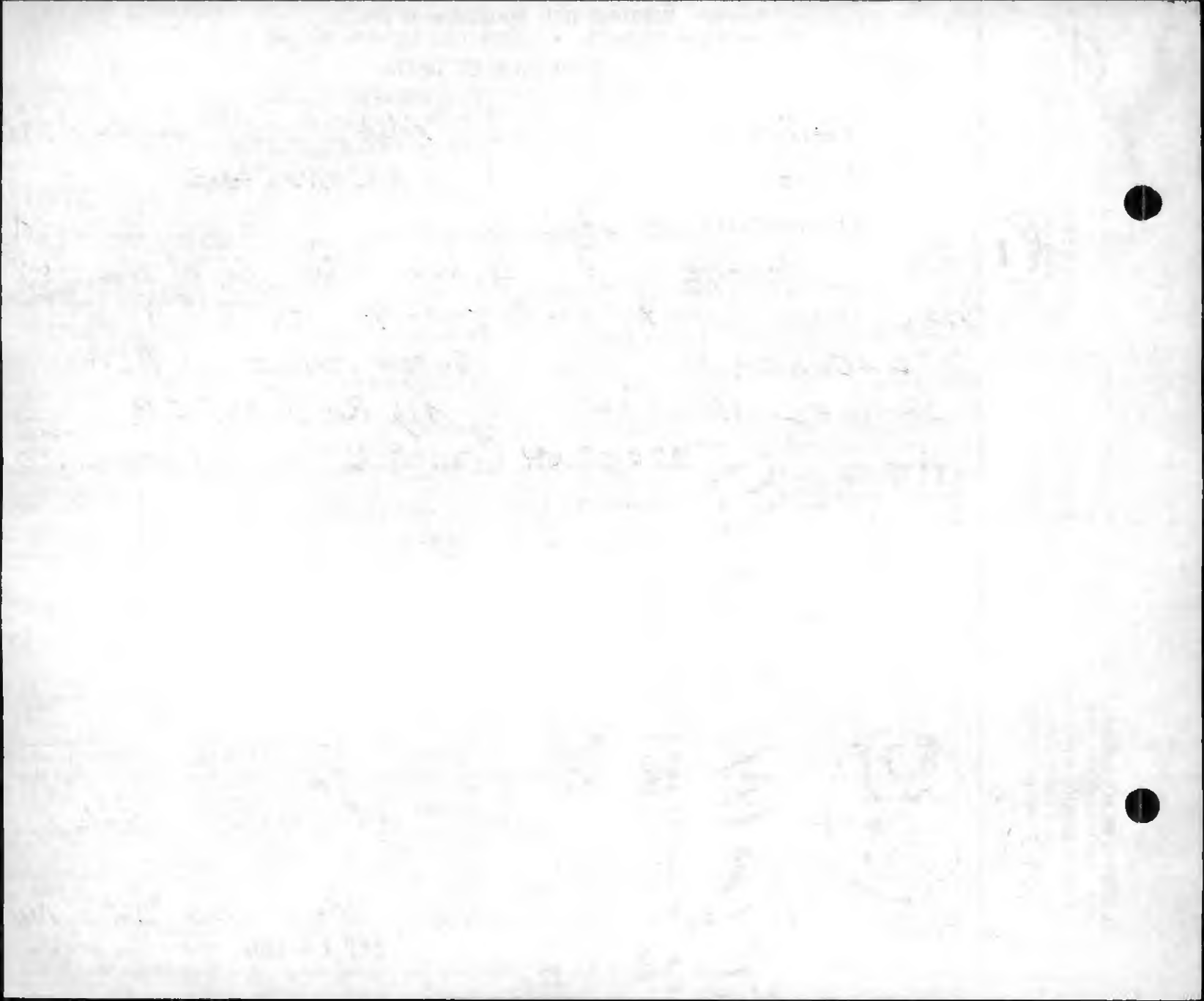
13012

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Talbot</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY in lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAESONVILLE</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>George</u> Middle <u>H</u> Last <u>Wilson</u>			<b>4. DATE OF DEATH</b> Month <u>Sept.</u> Day <u>12</u> Year <u>1967</u>				
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9-11-90</u>		<b>9. AGE</b> (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>QUEEN ANNE</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			<b>13. FATHER'S NAME</b> <u>SAMUEL WILSON</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>MYRA CARTER</u>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				
<b>16. SOCIAL SECURITY NO.</b> <u>220-07-0024</u>			<b>17. INFORMANT</b> <u>GEORGE WILSON, JR. GAESONVILLE MD</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic nephropathy</u> DUE TO (c) _____					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>(?/)</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a.m. _____ p.m. _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg, etc.)			
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>27 Aug</u> , 19 <u>67</u> , to <u>12 Sept</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12 Sept</u> , 19 <u>67</u> , and that death occurred at <u>7 p.m.</u> , from causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>Thurston Harrison</u>			<b>22b. DATE SIGNED</b> <u>14 Sept 67</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>THURSTON HARRISON</u>		
<b>22d. ADDRESS</b> <u>Easton Maryland</u>			<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				
<b>23b. DATE THEREOF</b> <u>9-16-67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GAESONVILLE</u>		<b>23d. LOCATION</b> (City or Town) (County) (State) <u>GAESONVILLE - QUEEN ANNE MD</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Dashfield Funeral Home</u>			<b>25a. REC'D BY REGISTRAR</b> DATE <u>SEP 15 1967</u>				
<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			<b>25c. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10/19/67  
 A34



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

13009

**CERTIFICATE OF DEATH**

13013

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>md.</b> b. COUNTY <b>Q.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Centreville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>RFD #1 Box 23</b>	
3. NAME OF DECEASED (Type or print) First <b>LIDA</b> Middle <b>M</b> Last <b>WRIGHT</b>		4. DATE OF DEATH Month <b>9</b> Day <b>10</b> Year <b>19 67</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-15-11</b>
9. AGE (In years lost birthday) yrs. <b>56</b>		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM DAWKINS</b>		14. MOTHER'S MAIDEN NAME <b>LUCY MACKABEE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>MRS. WALTER O'HALL</b>		Address <b>CENTREVILLE MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> DUE TO (b) <b>of the cervix</b> DUE TO (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>Uncertain</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>5:40</b> P.M., from causes and on the date stated above.			
22a. SIGNATURE <b>Robert W. Trever</b> M.D.		22b. DATE SIGNED <b>9/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert W. Trever</b>		22d. ADDRESS <b>M.D. Easton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>SEPT. 13, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BRIDGEVILLE</b>	23d. LOCATION (City or Town) (County) (State) <b>BRIDGEVILLE DEL.</b>
24. FUNERAL DIRECTOR <b>Charles V. Moore Denton and</b>		25. REC'D BY REGISTRAR DATE <b>SEP 14 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

